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ABSTRACT

This survey collected extensive data from 770 county case managers, case manager supervisors, consumers, and service providers in Minnesota in order to provide a comprehensive description of case management practices serving individuals with developmental disabilities. The survey report describes current case management practices, identifies barriers to and gaps in services, and examines perceptions of the effectiveness of case management services. Following a review of the literature on case management, the survey methodology is presented. Analysis of survey results is organized by categories of the target groups: directors of county welfare and human service agencies, case management supervisors, case managers, consumers, service providers, school personnel, rehabilitation counselors, advocates, and public health nurses. An overall summary of results discusses: education and background of human services personnel; staffing patterns; case load; case management functions; case management time allocation; cooperative work among agencies; evaluation; barriers to delivery of effective services; gaps and duplication in services; perceptions of case management effectiveness in schools, public health, and county agencies; factors and strategies that contribute to effective case management; and recommendations. Samples of the nine case management survey forms sent to the targeted groups are included in an appendix. (JDD)

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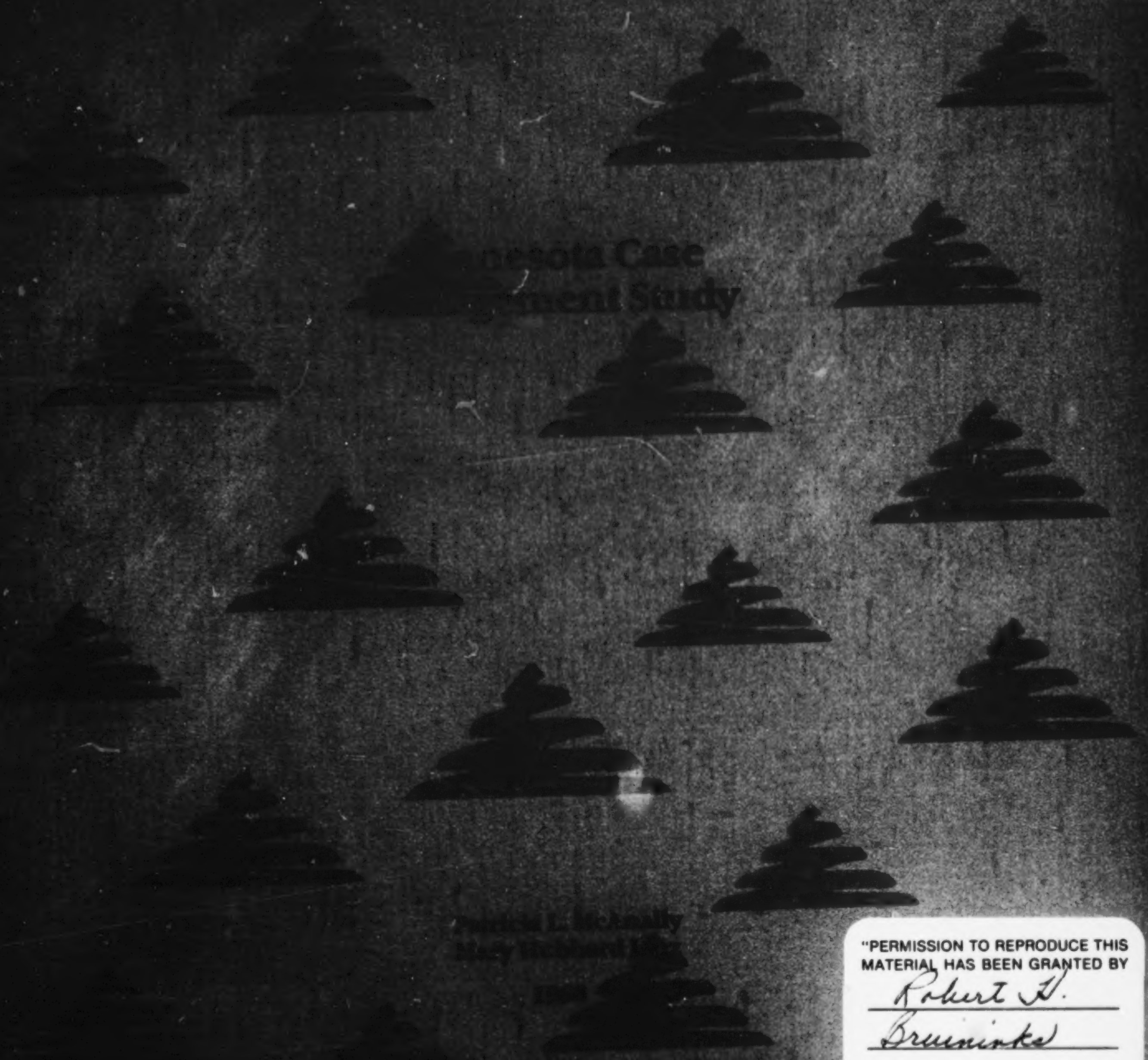

Minnesota Case Management Study

Patricia L. McAnally
Mary Hubbard Linz

1989

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MINNESOTA CASE MANAGEMENT STUDY

Investigators: Patricia L. McAnally, Ph.D.
Mary Hubbard Linz, Ph.D.

1988

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University of Minnesota
6 Pattee Hall
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CHAPTER ONE

Introduction

Planning and coordination on behalf of clients with developmental disabilities has long been a concern of social service, medical, and planning professionals. This concern is based on many factors, some having to do with the timely delivery of services, some with issues of cost, and others with providing appropriate services for clients and their families as their needs or circumstances change.

The reality faced by many clients with developmental disabilities is that they often have multiple needs which a single agency is hard pressed to meet. Thus, they may be receiving services from a variety of agencies and professionals at the same time. These agencies, programs, and professionals often have dissimilar goals, patterns of service delivery, and methods of operation. These factors can result in confusion for the client, and often create interagency and interprofessional conflict, gaps in services, and sometimes duplication of services.

The Problem

With increased numbers of individuals with developmental disabilities being served in the community, the coordination of appropriate services becomes an important immediate concern. The process of coordinating assistance to individuals with special needs is often described as case management services. The Developmental Disabilities Assistance and Bill of Rights Act of 1984 defines the term 'case management services' as such services to persons with developmental disabilities as will assist them in gaining access to needed social, medical, educational, and other services (Sec. 102, H), including:

"(i) follow-along services which ensure, through a continuing relationship, lifelong if necessary, between an agency or provider and a person with a developmental disability and the person's immediate relatives or guardians, that the changing needs of the person and the family are recognized and appropriately met; and

(ii) coordination services which provide to persons with developmental disabilities support, access to (and coordination of) other services, information on programs and services, and monitoring of the person's progress."

The Act's definition of "developmental disability" attests to the appropriateness of providing case management to persons with developmental disabilities:

The term 'developmental disability' means a severe, chronic disability of a person which --

"(A) is attributable to a mental or physical impairment or combination of mental and physical impairments;

(B) is manifested before the person attains age twenty-two;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the following areas of major life activity: (i) self-care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, and (vii) economic self-sufficiency; and

(E) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated."

The provision of service coordination for persons with developmental disabilities has presented new challenges to case managers and to existing case management systems. Effective case management systems are essential if individuals with developmental disabilities are to have access to all services that will facilitate their achievement of independence, productivity, and community integration. Human services in Minnesota are basically decentralized with counties charged with the responsibilities for providing appropriate services and service coordination for citizens with developmental disabilities. No formal statewide model is available, and because of diversity of geographic locations, resources, service options, and case loads, case management services may vary significantly among counties. Current observations indicate that fragmentary and conflicting responsibilities exist among case managers, educators, and service providers. Wray and Wieck (1985) stated that there is a lack of "systematic ongoing evaluation at a regional or state level that could provide a basis by which decision makers could make adjustments in service coordination to improve the integration of persons with developmental disabilities into their home communities" (p. 224).

In 1981, the Minnesota legislature passed amendments to Minnesota Statutes, section 256E.08, subdivision 1, thereby granting counties the authority and responsibility for assessment, protection of safety, health, and well-being, and providing a means of facilitating access to services for citizens with handicapping conditions. A basic framework for a case management system was established by rules promulgated under this statute.

Rule 185, first promulgated by the Department of Human Services in 1977, was revised in 1981 and 1987. This rule establishes that the individual counties of Minnesota will be responsible for the provision of case management services to all persons with developmental disabilities who reside in that county. Counties may do this directly through their county social services agency or may contract with another agency to provide these services with the requirement that the guidelines of Rule 185 be followed regarding the provision of those services. The case manager is given the 'gate-keeping' responsibility for all services provided to the clients and, as such, is responsible for "identifying the need for, seeking out, acquiring, authorizing, and coordinating services to persons with mental retardation. Case management includes monitoring and evaluating the delivery of the services to, and protecting the rights of, the persons with mental retardation" (Rule 185, 9525.0015, subpart 4, line 23-30). An interdisciplinary team approach must be utilized in establishing the diagnosis as well as in the development of the Individual Services Plan and the Individual Habilitation Plan. The overall purpose is to "ensure that each person with mental retardation who applies for services or whose legal representative applies for services, receives a diagnosis and assessment of current condition, and that, based on the information gathered, services are designed, arranged, provided, and monitored so that the services meet the level of the person's need in the least restrictive environment and in a cost-effective manner. (Rule 185, 9525.0025, subpart 2, line 4). In addition to the services mentioned above, case management also includes methods for providing, evaluating, and monitoring the various services which are identified in the plan.

In order to determine what adjustments need to be made in case management systems and what changes need to be made in the areas of training and technical assistance for case managers, the current case management system and the functions performed by case managers at the present time must first be more clearly described. Identification of effective case management functions as well as gaps in and barriers to services coordination are also necessary, along with other relevant and specific information from providers and consumers/parents/guardians. The Minnesota University Affiliated Program on Developmental Disabilities (MUAP) conducted this survey to collect extensive data from multiple sources, including county case managers, case manager supervisors, consumers, and service providers so that a comprehensive description of current case management practices could be drawn from the information.

Research Questions

The survey questionnaires were designed to provide information that would address the following questions:

(1) What is the current status of case management practices in Minnesota?

(2) What barriers impede the effective delivery of case management services?

(3) What gaps and duplications exist in the provision of case management services to individuals with developmental disabilities?

(4) What programs or program functions of case management services are perceived as effective by clients and/or parents/guardians, providers, and case managers?

(5) What factors and strategies contribute to the effective delivery of case management services?

(6) What strategies could be used to improve the availability, effectiveness, and coordination of case management services in Minnesota?

CHAPTER TWO

REVIEW OF LITERATURE

The evolution of case management has its roots in the development of professionalized social work and publicly-funded human services. Research on the effectiveness of case management is also based in research exploring the effectiveness of social work practices and in evaluation studies of existing case management systems. In this section, the historical development of case management is reviewed, including how it differs from traditional social work and its evolution through federal laws and guidelines. Empirical research on the effectiveness of case management systems and of case management practices is also reviewed. Summaries of previous evaluations of statewide case management systems in other states and in Minnesota conclude this section.

History of Case Management

As early as the 19th century charitable organizations were providing services to persons who were poor and needy, an undertaking which predated any organized government role in the delivery of human services. The current delivery of human services is derived from the fragmented and duplicative efforts of these early, singular organizations, and during the intervening years, agencies have struggled with the development of comprehensive and unified strategies for delivering services.

A significant impact in the development of organized services occurred with the Social Security Act of 1932. In addition to establishing a major role for the federal government in meeting human needs, the Social Security Act also attempted to bring together several different categorical programs (e.g., public assistance, social insurance, maternal and child health) in a logical relationship (Rice, 1977).

The next great wave of federal legislation for social services, occurring in the 1960s, precipitated efforts to coordinate services and to focus existing and newly formed resources in systematized directions toward target problems. Numerous problem-centered legislative actions, such as the Mental Health Act, Comprehensive Health Services Act, Office of Economic Opportunity, and Model Cities legislation attempted to bring together previously separated programs in medicine, welfare, mental health, and planning to function in harmony (Rice, 1977).

However, the proliferation of initiatives in the 1960s led to the development by the 1970s of a large number of separately established social service agencies, organized around the concept of a single service or set of services. The result was a service delivery system specialized and compartmentalized into separate bureaucracies in such diverse areas as vocational rehabilitation, mental health, child welfare, and developmental disabilities.

In 1962, the President's Panel on Mental Retardation expressed concern for the effectiveness with which consumers could secure needed services, and proposed the "continuum of care" as a critical consideration for service system planners. In response to strong advocacy for alternatives to institutionalization, many of these concepts suggested in "A Proposed Program for National Action to Combat Mental Retardation" (President's Panel on Mental Retardation, 1962) would later evolve into what is now called case management.

The mixed success of the social services programs in the 1960s led to efforts to place many services into one coordinated administrative stream. The relative explosion in human services initiated in the 1960's "Kennedy era" gave rise to numerous programs, criticisms of those programs, and strategies for improving services. As a result, critical attempts were made to establish programs that would integrate services, and these programs became the fore-runners of case management.

The term "services integration" was coined to describe federally initiated activities which attempted to build linkages among human service programs and bring coordination to the social service system. In 1971, the Secretary of Health, Education and Welfare, Elliot Richardson, declared services integration as a policy objective in a memorandum entitled "Services Integration: Next Steps." The objectives of services integration programs were: (a) the coordinated delivery of services for the greatest benefit to the people, (b) a holistic approach to the individual family unit, (c) the provision of a comprehensive range of services locally, and (d) the rational allocation of resources at the local level to be responsive to local needs (Richardson, 1971).

That year, 45 pilot demonstration projects called the Services Integration Targets of Opportunity (SITO) were initiated to establish new state or local interagency linkages. Under these grants, numerous techniques were developed and demonstrated including client tracking systems, information and referral systems, interagency planning and service delivery agreements, computerized resource inventories, and management reorganization projects (Mittenthal, 1975). Although some SITO projects were successful, some were unsuccessful due to a number of factors, such as, a history of elaborate designs that were never implemented, resistance from local categorical programs, and withdrawal of federal research and development funds after the three-year pilot program (John, 1976).

For persons with developmental disabilities, Intagliata (1981) has postulated that the pressing need for case management has emerged in response to two major forces that have radically altered the human services environment over the last two decades. The first was the rapid expansion of human service programs that erupted throughout the sixties and into the early seventies. As a consequence of this expansion, the overall availability of services increased, although categorically, leading to the complex, fragmented, duplicative, and uncoordinated system currently available (Wray & Wieck, 1985). Deficiencies of the service system have proliferated in the evaluation literature in consistent references to "system overlap," "system duplication," "fragmented system" and "clients falling between the cracks" (Caragonne, 1984). A number of studies in the 1970s showed that services provided to persons with handicaps and their families were complex, uncoordinated, and confusing to those who needed them most and who most needed easy access to them (Kakalik et al., 1973; Office of Management and Budget, 1978). Randolph, Spurrier and Abramczyk (1981) found that the person with a developmental disability, in particular, runs the risk of being one of the most poorly served of social service clients. In addition, judicial attention began to play a major role in the development of services. In 1977 in the major litigation of Halderman v. Pennhurst, the federal district court found that "lack of accountability in case management was the central reason for the lack of movement from institution to the community." (Laski & Spitalnik, 1979, p. 1).

The second force that radically changed the human services system and contributed to the importance of case management was the deinstitutionalization movement. Moving from the "under one roof" model of services provided in the institution to the diffused care and support system in the community brought about a different set of significant problems. The negative consequences of the failure to provide adequate and appropriate community care to deinstitutionalized persons received widespread attention in the 1970s (Bassuk & Gerson, 1978; GAO Report, 1976; Lamb & Goertzel, 1971; Segal & Aviram, 1978; Willer, Scheerenberger & Intagliata, 1978). By the end of the 1970s, the need for case management to better coordinate services was, again, the focus of renewed attention in human service programs. This focus was in response to various federal mandates in different laws regarding human services and was partly a function of many positive evaluation reports detailing the benefits derived from the use of case managers (Gans & Horton, 1975).

During the 1970s, it also became evident that the mental health deinstitutionalization programs had led to many persons with mental health problems being "dumped" in the community without sufficient support. The National Institute of Mental Health proposed a comprehensive network of services, a coordinated community support system for such persons, with the key element being case management as the mechanism for coordinating all system efforts (Rice, 1977). In these community support programs, the case manager was designated as having case coordination responsibility within existing community resource networks.

Efforts by professionals, consumers, and advocates for persons with developmental disabilities also continued into the 1970s, resulting in federal support monies and federal and state legislation which encouraged the development of services to meet the individual needs of each client. Congress passed the first Developmental Disabilities Act in 1974 which specifically identified case management as a priority service component. The Developmentally Disabled Assistance and Bill of Rights Act (P.L. 95-602) included a requirement that each state receiving federal monies for developmental disabilities would allocate a substantial portion of its federal funds under the Act to at least one of four priority services; "case management" was among them and remained a priority service in the Developmental Disabilities Act of 1984. As a result of the "priority service" requirement, there has been an increased need for information about case management and guidance in planning for its implementation under different circumstances. Many individual states began to enact legislation regarding case management that complemented the federal action in the late 1970s and early 1980s. In 1981, the Minnesota legislature passed amendments to Minnesota Statutes (Section 256E.08, Subdivision 1), which established a basic framework for the functions of case managers in the state.

With the proliferation and the increased cost of services, the complexity of the service system multiplied for all types of persons with disabilities requiring long-term care. In each of the fields addressing persons with long-term care needs, some strategy regarding coordination of services has evolved and has included case management. Potentially large deficits in state Medicaid budgets for long-term care have also forced many state budget personnel, human services, and Medicaid directors to seek ways to control costs. Sufficient evidence exists regarding cost reduction possibilities with coordinated community services and alternatives to institutionalization, to move vigorously toward the development of these alternatives. Hence, case management has been viewed as a key element in cost control (Simpson, 1982).

In services for elderly persons with health problems, case management has increasingly become a critical factor (Simpson, 1982). Given that chronic illness affects more than 80% of the elderly in the country, these persons are proportionally greater consumers of the nation's health care services. This increasing demand for health care services has created a crisis in health care delivery along with a crisis of hugely increasing Medicaid expenditures for nursing home care for elderly citizens. Many states (e.g., Wisconsin, New York, Virginia, and Minnesota) have developed community care programs encouraging elderly persons to remain at home as long as possible. Case management has been included as a necessary component of these programs, which have in some cases included disabled as well as elderly individuals. Several studies have indicated that in this type of coordinated care, case management can make a difference in public costs. Seidl, Applebaum, Austin, and Mahoney (1983) showed two key results in a vigorously controlled random-sample study in Wisconsin focused on systemized case management for long-term care clients. One finding was that appropriate community care was at least no more costly than nursing home care, even with all the administrative and start-up costs involved in the development of the community care services. Secondly, one of the key factors in keeping health care costs at a minimum was that case managers played a primary role in significantly reducing emergency room visits.

This type of coordinated approach to care has also been adopted from the long-term care field to health services for the general population. Given the rising costs of health care in all areas, health/maintenance organizations and coordinated health plans have incorporated the concept of unifying services with one deliverer to address some of these same cost concerns. The Health Care Financing Administration has adopted a system of rewarding and penalizing physicians based on their performance in the control and reduction of costs (Berenson, 1985). Primary care physicians, who function as 'case managers' in these program, are responsible for providing all primary health care services as well as coordinating and approving the provision of other health care, including specialty care and hospitalization.

Despite much development and organized system change in many diverse areas of social and health services, there is still mixed evidence that case management efforts have been effective with clients with developmental disabilities (Bertsche & Horejsi, 1980; DeWeaver, 1983; Walker, 1980). With the increasing demand for services for this population and a continuing scarcity of such services, it seems inevitable that the needs of some clients with developmental disabilities will not be fully served (Randolph, et al, 1981) and that the need for development of effective case management will continue. In addition, the evolution of effective case management systems for all clients needing long-term care and coordination of services will continue to be a pressing demand on human services systems for some time to come.

Definitions of Case Management

There is little agreement on the scope and definition of case management, and upon all the activities and functions of persons designated as case managers (National Conference on Social Welfare, 1981). However, although definitions of case management differ, there is some growing consensus of the core concepts. Intagliata (1981, p. 102) defines case management as "a process or method for ensuring that consumers are provided with whatever services they need in a coordinated, effective, and efficient manner." He notes that the specific meaning of case management depends on the system that is developed to provide it. For case management systems, two contextual factors are particularly important to consider: (1) the nature of the client population to be served, and (2) the nature of the existing service system. These two factors together shape the goals, functions, and structures that define a given case management system.

Caragonne (1984) proposed that emphasis in case management should focus on service availability, accessibility, responsiveness, continuity, coordination, monitoring/advocacy, and accountability. Case management is appropriate when clients with multiple problems and needs are unable to define, locate, secure, or retain the necessary resources and services of multiple providers on an ongoing basis. The three key components are accountability, accessibility, and coordination. Specifically, Caragonne proposed that the functions of line-service personnel in a case management system are to:

- identify the full range of services needed;
- identify the range of resources available, inclusive of client natural support resources and public community resources;
- coordinate the activities of all services and resources;
- refer clients to all needed resources;
- monitor and follow-up to determine if services are received;
- monitor and follow-along to prevent or identify problems in service provision through ongoing contacts with both clients, all services utilized, and the clients' natural support resources;
- assess and evaluate the effectiveness of all services/resources utilized.

Several major areas stand out as differentiating the role of the case manager from more traditional social work services roles (Caragonne, 1984). A traditional service model involves office contact between the hours of eight and five, with one service emphasis and little or no interagency contact. A provider has authority relative only to the activities of their caseload with little discretionary authority utilized by the caseworker. In case management, service settings shift from office-oriented, fixed appointment models to locations where clients live, work, and receive services. A major focus in case management is on the many systems of influence, rather than only on the behaviors of the client. Much more emphasis is put on interagency work and relationships. If there are difficulties with other agencies' services or resources, responsibility for resolution rests with the case manager rather than with the client, as it does with more traditional services. In case management, agency accountability rests with all services received by the client, not just those provided by the agency.

Case management involves advocacy, coordination, and monitoring of all collateral resources important to a client's networks of support. Three key areas distinguish traditional models of service from effective case management approaches:

- the scope of intervention in case management includes all relevant client systems;
- line worker autonomy and discretionary authority is commensurate with the additional responsibilities and accountability for service delivery; and
- the location of client contact is in a variety of environments and settings.

Despite much theoretical analysis of the differences between case management and traditional social work, Kurtz, Bagarozzi, and Pallane (1984) found that 38% of case management workers in Georgia saw no difference between social work and case management. He suggested that training programs may not be preparing social workers for all aspects of their job requirements.

The conceptual scope of case management has also recently expanded to include much more emphasis on families and on informal networks. For instance, Sister M. Vincentia Joseph and Sister Ann Patrick Conrad (1980) described the use of informal networks in a parish neighborhood model. Seltzer (n.d.) trained family members as case managers for elderly persons in an experimental study supporting the development of partnership between the informal and formal support networks.

Federal Role in Case Management for Persons with Developmental Disabilities

The Developmental Disabilities Act of 1975 (PL 95-602) established case management as a "priority service" and presented it as a mechanism to coordinate service needs in social, medical, educational, and other areas for as long as the services were needed, including lifelong if necessary. The Developmental Disabilities Act defined case management services as:

> ... such services to persons with developmental disabilities as will assist them in gaining access to needed social, medical, educational, and other services; and such term includes --
>
> (i) follow-along services which ensure, through a continuing relationship, lifelong if necessary, between an agency or provider and a person with a developmental disability and the person's immediate relatives or guardians, that the changing needs of the person and the family are recognized and appropriately met; and
>
> (ii) coordination services which provide the persons with developmental disabilities support, access to (and coordination of) other services, information on programs and services, and monitoring of the person's progress.

Individual plans are required in numerous other federal laws affecting persons with developmental disabilities, including the Rehabilitation Act (PL 93-516) and Education for All Handicapped Children Act (PL 94-142). Case plans are also required or encouraged in Title XX of the Social Security Act (PL 93-647) and Title XIX (Medicaid, PL 94-223). The Developmental Disabilities Assistance Act (PL 95-602) and the Mental Health Systems Act incorporate more specific requirements to establish increased accountability by mandating that every state develop a system of case management to serve the target population. It is within the scope of these federal guidelines that Minnesota developed the case management regulations of Rule 185.

Research on the Effectiveness of Case Management

Much of the literature on case management is conceptual rather than based upon empirical evaluation studies. For instance, many authors have described issues in case management (e.g., National Council on Social Welfare, 1981) and numerous authors, agencies, and organizations have developed standards for ideal or model case management programs (Morell, Straley, Burris & Covington, 1980; Wray, et al., 1985). Several authors have suggested roles for case management (Ashbaugh, 1981) as a front-line quality assurance and accountability process.

Some case management literature is organizational and efficiency-based, such as work by sociologists, organizational theorists, and industrial psychologists interested in explaining the variations in performance among and within organizations by focusing on worker characteristics, management processes, and organizational structure (Caragonne, 1984). In addition, most research on the empirical effectiveness of case management has been conducted on general social services clients, rather than solely on persons with developmental disabilities. Nevertheless, some of this empirical research is valuable in documenting the advantages of an integrated case management approach and pinpointing difficulties and problems in case management programs.

Effectiveness of Case Management Programs

The majority of the studies of the services integration demonstration projects were site-specific, highly descriptive, and predominantly process-oriented. However, Turner and Washington (Washington, 1974), in an attempt to obtain data on the populations served, developed methods to measure the impact of services provided by the East Cleveland Community Human Service Center. They used measures of client functioning and the behavior of the treated populations as dependent variables. When evaluating the means by which individuals may be moved from levels of dependency toward levels of independence, they concluded that client functioning was enhanced through integrated service systems.

Other evaluations of service integration projects reported that the use of case management teams and case manager linkages led to increases in the accessibility, comprehensiveness, and volume of services provided to clients (Baker & Northman, in press). Caragonne (1979) also reported that the use of case managers led to more effective packaging of client service plans, a greater range of services for clients, documented gaps and duplications in service networks, and generally greater organizational responsiveness to consumer needs.

An integrated rehabilitation service center in Arkansas was evaluated using a research design that compared client outcomes from groups of clients randomly assigned to two traditional and one integrated rehabilitation service program (Roessler & Mack, 1972). Outcome measures were divided into measures of "efficiency" (recidivism, referrals, acceptance/referral ratio, speed of service, agency closures, system closures, and drop outs) and measures of "effectiveness" (client change in attitudes and behavior, reduction of dependency, and client satisfaction). The theory was that more centralized case management and coordination would make services more effective. The conclusion of the study was that such barriers as ineffective leadership, conceptual confusion, and internal agency changes negatively affected the impact of both integrated and more traditional case management programs.

Some of the research on case management projects in community support programs has revealed that the use of case managers facilitates client access to services (Maverick Corporation, 1976); provides a necessary administrative link between program and consumer (Rosenberg & Brody, 1974); is more effective in packaging a complex sequence of services than traditional service models (Brody, 1974); documents gaps and duplications in service networks (Perlman, 1975; Bureau of Social Welfare, Maine, 1973); and promotes organization responsiveness to consumer needs (Caragonne, 1979).

One of the most promising models for effective case management is the Direction Service model described by Zeller (1980) and Brewer and Kakalik (1979). Some of the characteristics of existing programs which have adopted such a model are: that they use a client-centered approach and are separate from major service bureaucracies so that focus on a specific service is not emphasized. Determination of who should provide the Direction Service has been debated and the estimated cost per person may diminish its feasibility unless re-deployment of existing resources could significantly reduce these costs.

Characteristics of Case Managers and Case Management Systems

Some studies have evaluated numerous characteristics of case managers and/or case management systems that might influence the effectiveness of the programs or systems. For instance, Brody (1974) found that caseworkers spend more time in administrative tasks than in providing services to clients. Berkeley Planning Associates (1977) found that system-wide coordination of services, continuity of services to clients, and case manager effectiveness was more likely to occur in small, nonbureaucratized settings characterized by workers with increased training and education, more years experience in the specific problem field, smaller caseloads, and access to consultation. Also, the quality of case management services appears to be strongly related to the intensity of contact between client and case manager (BPA, 1977).

A number of studies (Baker et al, 1980; Caragonne, 1979; Graham, 1980) have indicated that case managers' activities are significantly shaped by the service systems in which they operate. If, for example, relatively few services are available, case managers spend relatively little time linking clients to services. However, when certain important support services are unavailable, case managers are likely to devote their own time to either directly providing or creating the needed services. Thus, to some degree, case managers' actual activities are ultimately shaped by the constraints of the environments within which they work, rather than by their formal job descriptions.

Evaluations of Other State Systems

Several states have conducted evaluation studies or surveys of the current status of their case management system. These studies will be described in some detail here, in order to provide a basis for comparison with the issues focused on in this current study. It should be taken into account, however, that most recommendations and conclusions generated in these studies were system-specific.

North Dakota conducted a study in 1985 of their case management system (Wray, Basuray, Miller, & Seiler, 1985), which primarily addressed the two different forms of case management in the state: external or regional case management, and internal or service provider case management. The surveyors were charged with making recommendations to reduce duplication between external and internal case management and to recommend a course of action for agencies and providers that would provide an optimum continuum of functions for persons with developmental disabilities. Three groups were surveyed concerning each of the two types of case management: members of the Association for Retarded Citizens, all regional case managers and coordinators, and all service providers.

The surveyors found that despite evidence of a genuine commitment to serving persons with developmental disabilities in policy and funding, and the recognition of the need for a sound case management system, there were indications of problems in communication, and indications that the state's human resources management policies would need to be modified with regard to service providers. Some of the negative factors which were identified as barriers to progress included a feeling of "us-them" between providers, regional and state staff, and consumers and parents. Secondly, specific breakdowns were identified in the training, recruitment, compensation and management of staff in provider organizations. Other problems included lack of leadership in program development by the state. Specific recommendations were made that concerned improving communications between state agencies and providers and parents, reducing paperwork, providing more specific training, resource development of local services to meet individual needs, and clarifying different roles for external and internal case management. The report concluded that there are legitimate service coordination functions to be performed by regional (external) case managers and distinct functions to be performed by program coordinators (internal) in service provider agencies. Extensive recommendations were made regarding the establishment of a powerful context at the state and local levels, establishment of components of case management, provision of contact points and information and referral, matching clients with case managers, gathering existing data, procuring new assessments, development of individual plans, identification of unavailable services, monitoring services, revision of individual plans, and quarterly reviews by regional case managers.

In the fall of 1982, the case management system in Kentucky for persons with developmental disabilities was evaluated by the University Affiliated Facility at the University of Kentucky in response to a request from the state Developmental Disabilities Council and the state office for persons with mental retardation (Human Development Program, 1983). The evaluation method used in the fourteen regions in the state was to judge actual performance against a prototype model for case management. The prototype used had been developed by the Rehabilitation Group, Inc. of Virginia. The evaluators proposed that any discrepancies found with the model would suggest that either actual practices or the model itself should be changed or improved.

The evaluation found that the prototype model contained too few administrative standards and too specific delivery standards, and that the roles of the case manager and case manager administrator were inconsistently addressed. Actual practices were not always consistent with the philosophy that should underlie a state-wide case management system. In particular, the issue of advocacy on behalf of the client received varying degrees of attention across the state. When the burden of advocacy was placed on case managers, they had little time to pursue monitoring and evaluation activities. Actual service delivery practices related more closely to the model definition than did administrative practices. Involvement of clients and their families in development of the individual habilitation plan was inconsistent and infrequent.

The evaluation concluded that, despite the many problems, the state was getting a reasonable return for its annual investment. Expenditures for case management were modest and cost effective in relation to total aggregate expenditures for human services. Overall, recommendations were made that case management be provided independently of service-providing agencies, that extensive parent involvement be maintained, and that a variety of agencies be involved in case planning and development. Corrections were recommended to improve policy guidelines; to develop training procedures for case managers, clients, parents, and advocates; and to provide technical assistance from the state level.

South Carolina evaluated its case management system in 1984 by determining whether current practices were in fulfillment of the system's objectives which were set forth at the time the system was put in place in 1979 (Randolph et al., 1984). This state had established a system of free-standing, independent case management agencies, responsible only for the coordination of services under the auspices of the state Developmental Disabilities Council. The evaluation revealed that in large measure the system was meeting its stated objectives and that case coordination had made a difference in enhancing the quality of life for persons with developmental disabilities. Major problems which were identified included public visibility, program operations, administrative relationships, case coordination functions, and interagency relationships. Given the low visibility of programs and since coordinators frequently indicated they were afraid of being flooded with referrals, the case management offices may not have been identifying clients with developmental disabilities who were not being appropriately served. Clients, parents, and providers appeared to have been only perfunctorily involved in development of individual habilitation plans. In addition, it was questionable to what degree the advocacy role of case coordination was being fulfilled.

In 1984, New York conducted a time and effort study of their case management system, with one-third of the state's case managers participating in the study (OMRDD, 1984). The major objectives of this study were to identify who received state case management services, what determined the amount of service received, the extent of overlap between state and voluntary case management, and the characteristics of the service systems, such as caseload size and organizational structures. This study found that the three most important variables associated with case management time spent on clients were the case manager's caseload size, the type of client's residence, and whether or not the client belonged to the Willowbrook class of persons deinstitutionalized under court order. Many management and organizational recommendations were made, including ratios of caseload sizes, to facilitate efficiency in the delivery of services.

An evaluation by Caragonne in 1984 of Georgia's case management system focused on how actual service activities and procedures compared to the service activities emphasized within the case management model of service. Using an intriguing study design, workers and their administrators at 14 sites were asked to first estimate the percentage of time spent in seven areas of activity: general agency contact, client-specific agency contact, direct services client contact, evaluation activities, recording and reporting, supervision, and travel. When workers estimated the proportion of time spent in each activity, a strong adherence to the case management model was revealed.

Supervisors also perceived their workers' activities as congruent with the model, especially in identifying that extensive time was spent in resource development and in arranging services for clients, moderate time in recording/reporting, and minimal time in supervision and travel. After their initial estimates, workers were asked to record their activities during a ten-day working period. Analysis of actual time and activities revealed a very different picture of time allocation. The data suggested that case managers vastly over-estimated the amount of time they spent in resource development, evaluation, and supervision. Little time was actually spent on the "core" model activities of case management: referral, coordination, follow-up and follow-along, evaluation and advocacy. The study revealed a strong emphasis on in-office work, with over-reliance on problem formulation/planning/documentation, all strong deterrents to development of effective case management.

The current case management system in Georgia was shown to have three primary features: office-based, administrative in nature, and overly prescriptive and descriptive of client problems. Also, many case managers operated in isolation from their settings, with a striking lack of supervision in the monitoring and support functions of case management. The offices operated in organizational vacuums, isolated within their agency systems, and lacked effective supervision, performance monitoring, and standards by which the quality of work could be judged. One of the six sites was remarkably different than the others in having the highest incidence of activities most in conformance with model case management activities. In an organizational analysis, this site was shown to differ from the others in having the following characteristics: high degrees of perceived leadership; a work climate which emphasized planning and efficiency rather than pressure; high degrees of support from other workers; rules and policies explicitly communicated in a timely, adequate, and effective way; supportive supervision; and moderate degrees of innovation. The site with the least adherence to the case management model of service reported low scores in leadership and task clarity, high degrees of perceived control and pressure, low peer cohesion, little innovation, and little communication.

Case Management Studies in Minnesota

The case management system in Minnesota has been previously evaluated in recent years, both as a separate system and as part of the entire human services system. Two of these studies were conducted by independent consulting firms.

In 1983, an evaluation examining many aspects of the service delivery system for persons with mental retardation was sponsored by the Association of Residences for the Retarded in Minnesota, the Department of Public Welfare, the Minnesota Association of Rehabilitation Facilities, and the Minnesota Developmental Achievement Center Association (Rosenau & Totten, 1983). Regarding case management, five overall recommendations were made:

1. All case managers should have four primary functions: assessing clients' needs, locating and planning services to meet clients' needs, linking and monitoring services, and advocating for the clients and for mentally retarded citizens in general.
2. Plans should lead toward an ideal of having a case manager client caseload of 1:25.
3. The state should initiate efforts to transfer central funding to case management agencies at the county level.
4. The state should take the initiative in developing a management information system that addresses the specific human needs of citizens with mental retardation.

5. Case management should begin with the development of a written plan that specifies ideal client goals and objectives, and specifies a reasonable time framework for moving to the ideal.

The report also recommended the following:

1. A clearer statement was needed of the case manager's monitoring responsibilities.
2. The State Department of Human Services should assign major responsibilities for overseeing case management to the counties but should retain limited oversight responsibilities.
3. Case managers should take a productive role in developing a greater number and variety of alternative services and placements.

Also in 1983 under a contract with the Department of Human Services, the Health Planning and Management Resources Inc. (1983) conducted a study of the case management system in Minnesota. They interviewed individuals from state, county, and public and private agencies regarding the current status of case management in their systems, and developed an integrated case management model that could be used by county social services and health agencies in working with disabled adults. This model articulated the role of the case manager. In addition, recommendations were made to the Department of Human Services regarding the development of case management, including training and caseload standards.

The delivery of case management has also been examined by the Court Monitor for the Welsch v. Levine consent decree. The semi-annual report (1/84-6/84) of the Monitor noted that case management is a crucial and pivotal component in the delivery of services to persons with developmental disabilities. Problems identified were:

1. conceptualization of the role of case management and managers was restricted;

2. few case managers are qualified or trained for the job; and
3. no commonly available professional training was available for case managers.

The report made the following recommendations:

1. that a clear official description of the job of case management and the role of case manager be developed;
2. that a visible statewide training program be developed and be based on the defined and agreed-upon role of the case manager provided by the Department of Human Services; and
3. the practice of case management be monitored (audited) under the present concept and rule.

In the following year (1985), the Welsch court monitor conducted a questionnaire survey at the annual conference of the Minnesota Social Services Association. Although responses were primarily from the metropolitan counties, case managers, vendors, institutional staff, county personnel, staff of community programs, psychologists, and special educators were included. The survey identified that in two-thirds of the cases, providers chaired the team meetings for clients. Respondents identified major barriers to effective case management as: (1) caseload size and ratios, (2) lack of adequate services, programs or resources; and (3) training and lack of knowledge. Respondents identified major steps that could be taken to overcome barriers to effective case management in Minnesota in the following order of priority: (1) better qualified case managers and more training and sensitivity; (2) more direction and leadership from the state on the system of service delivery; and (3) better ratios and more client contact. The monitor concluded from the responses that the key issues for persons involved in case management in Minnesota were reduced caseloads, more expertise in developmental disabilities through training, and that the state displayed a lack of leadership, clarity of mission and commitment, as well as bureaucratic confusion and red tape.

Summary

Studies of formal service coordination efforts for persons with developmental disabilities seem to agree that case management systems have the potential for being efficient and effective systems for services coordination. However, regardless of geographic location, several common problems have been identified. Heavy client caseloads were commonly cited as a major factor negatively influencing the effectiveness of case managers. Additionally, inadequate training, ineffective leadership, and lack of role clarification were listed as frequent barriers. Characteristics perceived as promoting favorable outcomes were effective leadership, better training programs for case managers, increased involvement of families, supportive supervision, increased client contact, and small case manager-to-client ratios.

CHAPTER THREE

METHODOLOGY

Advisory Committee

An Advisory Committee was formed at the beginning of the project to provide suggestions and assistance in determining the target groups and in developing the survey questionnaires. The Advisory Committee was composed of 14 members and 2 alternates, one-half of whom were persons with developmental disabilities, their parents or guardians. The members of this committee also represented organizations providing services and advocacy for persons with developmental disabilities as well as county human services agencies. A list of Advisory Committee members is contained in Appendix A.

Target Population

The project staff and the Advisory Committee selected nine target groups as recipients of the survey questionnaire whose combined input could provide the information necessary to respond to the research questions.

Under Minnesota Rule 185, county departments of human services are vested with the primary responsibility for providing case management services to persons with developmental disabilities. Therefore, the primary focus of this study was upon three groups under the management of county human service agencies, namely:

- directors of county human service agencies
- county case manager supervisors
- county case managers

Provision of service coordination efforts to persons with developmental disabilities is also provided by other agencies and groups. For this reason, the advisory committee recommended that the study be expanded to include six other target groups:

- consumers
- service providers
- school personnel
- rehabilitation counselors
- advocates
- public health nurses

This exploratory study of additional target groups was considered important to gain the broadest possible perspective on local service coordination issues across different services agencies.

A mailing list of Directors of County Human Service Agencies was obtained from the Department of Human Services, Division for Persons with Developmental Disabilities. No mailing list was available for county case managers and supervisors. Survey questionnaires were mailed to the directors, and they distributed the appropriate questionnaire to case managers and supervisors. All 81 county directors, 125 county supervisors, and 291 county case managers in Minnesota received survey questionnaires.

A list of agencies and organizations that provide services for persons with developmental disabilities was obtained from the office of the Governor's Council on Developmental Disabilities. All of the 310 service providers on the list received questionnaires.

A mailing list for consumers was developed primarily from one source. The Court Monitor for the Welsh Decree settlement allowed the project staff to draw a random sample of names from the files of persons with developmental disabilities who had been released from institutions. Questionnaires were mailed to 270 people from the Court Monitor's office. The Association for Retarded Citizens/Minnesota (ARC/MN) permitted the project staff to include an article in their newsletter asking consumers and their families to call the MUAP if they were willing to respond to a survey questionnaire.

Five questionnaires were completed from this source. Additional names of advocates were obtained from the Parent Advocacy Coalition for Educational Rights (PACER), ARC/MN, and the Legal Advocacy Project for Persons with Developmental Disabilities in Minnesota. Sixty-six questionnaires were mailed to advocates whose names were on the lists received.

The Department of Health provided a list of 75 public health nurses. Survey questionnaires were mailed to all on the list. The Division of Rehabilitation Services (DRS) provided a mailing list which included all of the rehabilitation counselors in Minnesota who are employed by DRS. Survey questionnaires were mailed by DRS to all 148 counselors.

A mailing list for school personnel was purchased from the State Department of Education which included names of:

- teachers of students with moderate and severe mental retardation,
- teachers of children with autism,
- teachers of children with multiple handicapping conditions, and
- school social workers.

Questionnaires were mailed to 400 school personnel whose names were selected using a random sampling procedure.

Instrumentation

Questionnaire Development

The MUAP staff developed a questionnaire for each target group including, in each, a core set of questions which would allow comparisons of case management perceptions among groups. Common questions included the topics of effectiveness, duplications, and gaps in case management practices. Items on the questionnaires were designed to produce information that would respond to the following questions:

(1) What are current case management practices in Minnesota?

(2) What factors are barriers to effective case management practices?

(3) What, if any, gaps and duplications exist in current case management practices?

(4) What are the training needs of case managers?

(5) In what areas can improvements be made to enable case managers to become more effective?

The questionnaires were presented to the Advisory Committee for review and suggestions. After the recommended revisions were made, the forms were mailed to Advisory Committee members for their review and approval before the field test.

Questionnaire Field Test

The MUAP project staff selected the pilot population and telephoned each person selected to obtain cooperation in participating in the pilot study. Consent was obtained and the questionnaires were mailed in January of 1987. The pilot population, consisting of three to five persons from each target group, were asked to respond to each item and note difficulties encountered in understanding items and in providing the information requested. The questionnaire for rehabilitation counselors was piloted by a representative group of 15 counselors who met in St. Paul, in December. Using input received from the pilot population, the questionnaires were revised and sent to Advisory Committee members for their final input which was incorporated into the final draft of the questionnaires.

Data Collection Procedures

Initial Mailing

All survey questionnaires were mailed to the nine target groups during the first two weeks of May. A cover letter (see Appendix B) was sent with final copies of all questionnaires (see Appendix C). Because of the length of some of the questionnaires, an incentive was offered to all who completed and returned the survey form. As the MUAP staff received completed forms, coupons providing a $20.00 reduction in the registration fee for a September, 1987 case management conference were returned to those who completed the surveys. By the third week of June, approximately 34% of the target population had returned questionnaires.

Mail Follow-Up

During the third week of June, follow-up letters were sent to all populations except consumers and school personnel. The agreement with the Court Monitor allowed a one-time-only mailing for consumers. Since schools were closed for the summer, and teachers and social workers were no longer at their school addresses, the follow-up letter was not very effective, producing fewer than five additional responses from each of the seven target groups.

Telephone Follow-Up

A telephone follow-up was conducted during July. For each survey form, the Advisory Committee and the MUAP project staff selected 10 to 15 items that would yield important information. Four persons were trained as telephone interviewers and called all county directors, supervisors, and case managers who had not responded. (Names of case managers had previously been obtained from county agencies.) The telephone interviewers gave each person contacted the option of responding on the telephone or completing the written form and mailing it to the MUAP. Most elected to complete the original written form.

Numbers and Rates of Responses

By the second week of August, 770 questionnaires had been returned; 1,771 questionnaires were disseminated in the original mailing, resulting in an overall return rate of 43%. Response rates for different target groups, however, varied considerably. These variations are due to a variety of factors including additional efforts to conduct follow-up mailings and calls. The response rates by group are shown below:

Target Group	Number Sent	Number Received	Response Rate
		Primary Sample	
County Directors	81	62	77%
County Supervisors	125	66	52%
Case Managers	291	206	71%
Subtotal:	497	334	Average: 63.3%
		Secondary Sample	
Service Providers	310	138	45%
Rehabilitation Counselors	148	67	45%
Advocates	66	35	53%
Public Health Nurses	75	31	41%
Consumers	275	37	14%
School Personnel	400	128	32%
Subtotal:	1,274	436	Average: 38.3%
Grand Total:	1,771	770	43%

County case managers, supervisors, and directors were considered to be the three most important groups from which to obtain information for this survey. Adequate response rates were obtained from the case manager and county director groups, namely, over a two-thirds majority.

CHAPTER FOUR

RESULTS OF COUNTY HUMAN SERVICES SURVEY

The Case Management Survey was developed to assess nine different groups of personnel/individuals having some responsibilities for case management or receiving case management services. This chapter presents the results of the questions designed to address information and opinions of those who have primary responsibility for case management services in county human service agencies, namely: (1) Directors of County Welfare and Human Service Agencies, (2) Case Manager Supervisors, and (3) Case Managers. The data are illustrated on tables and relevant findings are described in the narrative for each of the three groups of respondents employed by county human service agencies.

Directors of County Welfare and Human Service Agencies

Staffing Patterns

The first part of the survey was directed to the number of personnel performing case management functions in the county agency, and recommended ratios of supervisors to case managers. Of the 60 respondents, representing 62 counties, 88% indicated that there was no supervisor, a part-time supervisor, or one full-time case manager supervisor for the agency. Table 1, Number of Case Manager Supervisors Working in County Welfare and Human Services Agencies, illustrates the results. Typically, counties had one or fewer case manager supervisors, with larger counties, as expected, employing the larger number of supervisors.

Directors were asked to indicate the number of actual case managers, by figuring full-time equivalents (FTE), working in the county agency. Over half of the counties employed between one and two case managers, with four of the large counties employing between 26 and 44 case managers. Table 2, Number of Case managers working in County

Table 1

Number of Case Manager Supervisors Working in County Welfare and Human Service Agencies by Frequency and Percentage

Case Manager Supervisors	Frequency	Percentage
0	8	13
.1	5	8
.2	1	2
.3	4	7
.4	1	2
.5	1	2
.8	1	2
1.0	31	52
2.2	1	2
3.0	3	5
4.0	2	3
5.0	1	2
7.0	1	2

Note: N = 60
Valid Cases = 60
M = 1.10
Standard Deviation = 1.29

Table 2

Number of Case Managers Working in County Agencies as Reported by Agency Directors by Frequency and Percentage

Case Managers	Frequency	Percentage
1.0	16	27
1.2	1	2
1.4	1	2
1.5	3	5
2.0	12	20
2.5	1	2
3.0	5	8
3.5	1	2
4.0	7	12
5.0	2	3
6.0	1	2
7.0	1	2
8.0	1	2
8.3	1	2
9.0	2	3
12.0	1	2
26.0	1	2
35.0	1	2
38.0	1	2
44.0	1	2

Note: N = 60
Valid Cases = 60
M = 5.14
Standard Deviation = 8.75

Agencies as Reported by Agency Directors, reports the results. The average number of case managers per county agency was 5.14, with a range of 1 to 44 FTE case managers.

The number of case management aides or paraprofessional workers in each county agency is illustrated in Table 3, Number of Case Aides Working in a County Agency. The most common responses (83% of respondents) indicated no use of case aides or one aide in the agency.

Directors were asked their opinion regarding the optimal ratio of supervisors to case managers. The range was a ratio of 1:00 to 1:20 supervisors to case managers. The most common responses clustered between 1:6 and 1:8. Table 4, titled Director Opinion of Optimal Ratio of Supervisors to Case Managers, shows the results.

Waiting Lists

Directors were questioned about whether case management services have been provided to all persons with developmental disabilities meeting the county's criteria for service. Eight of the 60 respondents (13.3%) failed to answer this question. Eighty-three percent indicated that he/she felt case management services had been provided to all, while 17% felt that all were not served by the established criteria.

All 60 directors responded to the question of whether the agency had a waiting list for persons with developmental disabilities in need of case management service. The majority (88%) indicated that no waiting list existed, while the remaining 12% said that there was such a list.

For those who responded that there was a waiting list, the question was posed whether those on such a list were provided interim services. Of the 12% who indicated that the agency had a waiting list, 75% indicated that interim services were provided as described, and 25% indicated that no services were given.

Table 3

Number of Case Aides Working in a County Agency by Frequency and Percentage

Case Aides	Frequency	Percentage
0	25	44
.5	3	5
.7	1	2
1.0	18	32
1.3	1	2
2.0	6	11
4.0	1	2
9.5	1	2
12.0	1	2

Note: N = 60

Valid Cases = 57

M = 1.04

Standard Deviation = 2.05

Table 4

Director Opinion of Optimal Ratio of Supervisors
to Case Managers by Frequency and Percentage

Ratio of Supervisors to Case Managers 1 : ___	Frequency	Percentage
0	1	2
1	1	2
4	2	4
5	4	9
6	13	28
7	7	15
8	12	26
10	5	11
12	1	2
20	1	2

Note: N = 60 cases
Valid cases = 47
M = 7.11
Standard Deviation = 2.88

Barriers

The next item was designed to identify possible barriers to the successful delivery of case management services and to rate the severity of the barrier on a scale of one to five. Table 5, Opinions Regarding Barriers to Delivery of Case Management Services, reports the results of all components of this item.

Of the sub-items which could be considered serious barriers (means of 3.5 or above), the amount of paperwork required of the case manager was identified as a definite drawback, with the client caseload size (too many), and number of required meetings to attend ranking next highest in severity, respectively. The two considerations felt to be least likely a barrier were the degree to which the case manager must interact with other agencies, and the level of the client's disability.

The second part of the "barriers" section pertained to staffing as it related to the delivery of case management services. Staff shortages, turnover, and lay-offs in management staff were assessed in this section. Table 6, Opinions Regarding Barriers to Delivery of Case Management Services: Staffing and Program Availability illustrates the results. Fairly clear-cut results indicated that staff shortages were considered a serious barrier, while staff turnover and lay-offs in management staff appeared not to be a problem by the majority of respondents.

The third section of this item on barriers related to the availability of services also shown on Table 6. Lack of program or other service options appeared to be one area where the majority of directors agreed that this was a barrier with the next serious barrier being lack of appropriate residential service.

The fourth section addressed funding issues. Table 7 identified two areas which appeared to be problems as ranked by the majority of directors, namely insufficient funds (71%) and restrictions in the use of funds (78%).

Table 5

Opinions Regarding Barriers to Delivery of Case Management Services by Frequency and Percentage

	1 Never a barrier		2 Seldom a barrier		3 Often a barrier (>50%)		4 Almost always a barrier		5 Always a barrier		M	Standard Deviation	Valid Cases
General Considerations	f	%	f	%	f	%	f	%	f	%			
Client's level of disability	12	20	29	48	15	25	4	7	-	-	2.18	.83	60
Service Providers	1	2	37	62	21	35	1	2	-	-	2.37	.55	60
Experience/expertise of case manager	5	8	39	65	15	25	-	-	1	2	2.22	.67	60
Degree of family involvement	2	3	30	50	28	47	-	-	-	-	2.43	.56	60
Degree to which case manager will have to interact with other agencies	7	12	40	67	10	17	3	5	-	-	2.15	.69	60
Travel time/distance to client residence	6	10	23	39	24	41	5	8	1	2	2.53	.86	59
Case manager's current client caseload size	2	3	8	14	18	31	16	27	15	25	3.58	1.12	59
Amount of paperwork required of case managers	1	2	3	5	14	23.7	18	30.5	23	38.9	4.0	1.0	59
Number of meetings case managers are required to attend	1	2	9	15	25	42	14	24	10	17	3.39	1.0	59
Other: Please specify													

Note: N = 60

Table 6

Opinions Regarding Barriers to Delivery of Case Management Services by Frequency and Percentage: Staffing and Program Availability

Issue	1 Never a barrier		2 Seldom a barrier		3 Often a barrier (50%)		4 Almost always a barrier		5 Always a barrier		M	Standard Deviation	Valid Cases
Staffing Barriers	f	%	f	%	f	%	f	%	f	%			
Staff shortages	3	5	16	27	15	25	12	20	13	22	3.27	1.23	59
Staff turnover	7	12	32	55	13	22	2	3	-	-	2.38	.99	58
Reduction in force of management staff	34	65	17	33	1	2	-	-	-	-	1.37	.53	52
Program Barriers	f	%	f	%	f	%	f	%	f	%	M	Standard Deviation	Valid Cases
Lack of residential program options	3	5	19	32	30	51	7	12	-	-	2.70	.75	59
Lack of day program options	4	7	26	44	22	37	7	12	-	-	2.54	.80	59
Lack of other program/ service options	2	3	19	32	29	49	9	15	-	-	2.76	.75	59
Difficult access for programs/services	4	7	30	52	15	26	9	16	-	-	2.5	.84	58

Note: N = 60

Table 7

Opinions Regarding Barriers to Delivery of Case Management Services by Frequency and Percentage: Funding

Issue	1 Never a barrier		2 Seldom a barrier		3 Often a barrier (50%)		4 Almost always a barrier		5 Always a barrier		*M*	Standard Deviation	Valid Cases
Funding Barriers	f	%	f	%	f	%	f	%	f	%			
Insufficient funds	2	4	11	24	13	29	9	20	10	22	3.31	1.20	45
Delays in receiving funds for client services	4	7	26	47	13	24	10	18	2	4	2.64	.99	55
Restrictions in use of funds	1	2	11	20	25	45	13	24	5	9	3.18	.93	55

Note: N = 60

Administration Issues

The next section related to county administration concerns. An overwhelming majority of directors felt that planning, coordination, and reorganization within the agency were not barriers. Table 8, Opinions Regarding Barriers to Delivery of Case Management Services: County Administration, describes the results.

For most of the items listed under interagency administration, the majority of directors felt that potential problems listed were seldom barriers to service (see Table 9). These were: lack of routine planning, difficulty in communication, confidentiality issues, lack of information about other agency resources, inappropriate referrals, duplication of services, multiple individual plans for a single client, clients "falling into the cracks" between agencies, lack of clear understanding of which agency is responsible for case management, and coordination problems with multiple case managers. The only item that was fairly evenly split regarding director opinion was the concern over multiple individual plans for a single client.

Cooperative Work Between Agencies

This section addresses the level of cooperative work which exists between agencies and a projection of what "should" exist (the ideal) between agencies in the opinion of the director. Tables 10-14, Degree of Cooperative Work Between County Agency and specific agencies or organizations, follows. Sixty-seven percent of the directors felt that there was "moderate" to "much" cooperative work between their agency and the Department of Human Services with 98% indicating that there should be more cooperation between their agency and the Department of Human Services. The least cooperative work appears to exist between the county welfare and human service agency and the university, and the county agency and community associations. Other low-ranked targets of cooperative work were (from the least upward): the Area Vocational Technical Institute (AVTI), community associations, volunteer organizations, and the criminal justice

Table 8

Opinions Regarding Barriers to Delivery of Case Management Services by Frequency and Percentage: County Administration

	1 Never a barrier		2 Seldom a barrier		3 Often a barrier (50%)		4 Almost always a barrier		5 Always a barrier		M	Standard Deviation	Valid Cases
Barriers	f	%	f	%	f	%	f	%	f	%			
Lack of routine planning and coordination within own agency	12	21	36	64	5	9	3	5	-	-	1.98	.73	56
Coordination between program units	14	25	28	68	4	7	-	-	-	-	1.82	.54	56
Internal reorganization	20	36	33	60	2	4	-	-	-	-	1.67	.55	55

Note: N = 60

Table 9

Opinions Regarding Barriers to Delivery of Case Management Services by Frequency and Percentage: Interagency Administration

	1 Never a barrier		2 Seldom a barrier		3 Often a barrier (50%)		4 Almost always a barrier		5 Always a barrier		M	Standard Deviation	Valid Cases
Barriers	f	%	f	%	f	%	f	%	f	%			
Lack of routine planning and coordination	4	7	40	73	8	15	3	5	-	-	2.18	.64	55
Difficulty in communications	1	5	40	73	8	15	2	4	-	-	2.13	.61	55
Confidentiality issues	13	24	37	67	4	7	1	2	-	-	1.87	.61	55
Lack of understanding about resources	8	15	37	67	9	16	1	2	-	-	2.06	.62	55
Inappropriate referrals	8	15	42	76	5	9	-	-	-	-	1.95	.49	55
Duplication of services	9	16	40	73	4	7	2	4	-	-	1.98	.62	55
Multiple individual plans for a single client	6	11	22	40	17	31	2	4	8	15	2.71	1.18	55
Clients "falling into the cracks" between agencies	3	6	34	63	13	24	4	7	-	-	2.33	.70	54
Lack of clear understanding of which agency is responsible for client's case management	9	16	31	56	10	18	3	5	2	4	2.24	.92	55
Multiple case managers/ client coordinators for a single client	11	20	29	53	12	22	3	5	-	-	2.13	.80	55

Note: N = 60

Table 10

Degree of Cooperative Work Between County and State Department, School Districts, and Local Rehabilitation Services

Group:		Existing:					What Should Be:				
State Department	Code	f	%	M	SD	VC	f	%	M	SD	VC
None	1	1	2	2.79	.70	52	0	0	3.7	.51	50
Slight	2	16	31				1	2			
Moderate	3	28	54				13	26			
Much	4	7	13				36	72			
School Districts											
None	1	0	0	2.91	.66	53	0	0	3.67	.55	51
Slight	2	14	26				2	4			
Moderate	3	30	57				13	25			
Much	4	9	17				36	71			
Local Rehabilitation Services											
None	1	2	4	2.69	.73	52	1	2	3.52	.65	50
Slight	2	18	35				1	2			
Moderate	3	26	50				19	38			
Much	4	6	11				29	58			

Note: N = 60

f = frequency. M = mean. SD = standard deviation. VC = valid cases.

Table 11

Degree of Cooperative Work Between Agency and Mental Health Centers, Criminal Justice System, and Developmental Achievement Center (DAC)

		Existing:					What Should Be:				
Group:	Code	f	%	M	SD	VC	f	%	M	SD	VC
Mental Health											
None	1	2	4	2.96	.76	53	1	2	3.58	.64	50
Slight	2	10	19				1	2			
Moderate	3	29	55				16	32			
Much	4	12	23				32	64			
Criminal Justice											
None	1	4	8				-	-			
Slight	2	24	46				11	22			
Moderate	3	20	38				22	45			
Much	4	4	8				16	33			
Developmental Achievement Center (DAC)											
None	1	-	-				-	-			
Slight	2	6	11				2	4			
Moderate	3	11	21				7	14			
Much	4	36	68				42	82			

Note: N = 60. f = frequency. M = mean. SD = standard deviation. VC = valid cases.

Table 12

Degree of Cooperative Work Between County Agency and Residential Providers, Sheltered Workshops, and Voluntary Advocacy Agencies

Group:		Existing:					What Should Be:				
Residential Providers	Code	f	%	M	SD	VC	f	%	M	SD	VC
None	1	-		3.38	.56	53	-	-	3.75	.44	51
Slight	2	2	4				-	-			
Moderate	3	29	55				13	25			
Much	4	22	42				38	75			
Sheltered Workshops											
None	1	1	2				-	-			
Slight	2	9	17				3	6			
Moderate	3	28	53				17	33			
Much	4	15	28				31	61			
Voluntary Advocacy Agencies											
None	1	9	18				3	6			
Slight	2	25	49				9	19			
Moderate	3	11	22				21	44			
Much	4	6	12				15	31			

Note: N = 60. f = frequency. M = mean. SD = standard deviation. VC = valid cases

Table 13

Degree of Cooperative Work Between County Agency and Community Associations and Social Security

Group:		Existing:					What Should Be:				
Community Association	Code	f	%	M	SD	VC	f	%	M	SD	VC
None	1	12	23	2.08	.79	52	5	10	2.71	.91	49
Slight	2	26	50				14	29			
Moderate	3	12	23				20	41			
Much	4	2	4				10	20			
Social Security											
None	1	4	8	2.71	.85	52	2	4	3.18	.86	49
Slight	2	16	31				8	16			
Moderate	3	23	44				18	37			
Much	4	9	17				21	43			

Note: N = 60
f = frequency
M = mean
SD = standard deviation
VC = valid cases

Table 14

Degree of Cooperative Work Between County Agency and University and Area Vocational Technical Institutes (AVTI)

Group:		Existing:					What Should Be:				
University	Code	f	%	M	SD	VC	f	%	M	SD	VC
None	1	26	53	1.67	.85	49	9	19	2.44	.98	46
Slight	2	15	31				15	33			
Moderate	3	6	12				15	33			
Much	4	2	4				7	15			
AVTI											
None	1	22	44	1.84	.89	50	10	21	2.56	1.09	48
Slight	2	16	32				13	27			
Moderate	3	10	20				13	27			
Much	4	2	4				12	25			

Note: N = 60
f = frequency
M = mean
SD = standard deviation
VC = valid cases

system. With all other agencies, the majority showed a current emphasis on "moderate" to "much" cooperative work with the county welfare and human services agency. As expected, those agencies administered by or funded through the State Department of Human Services showed high levels of cooperative work, such as the county human service agencies (67%), the developmental achievement centers (89%), and the mental health centers (77%). Critical placement options for persons with developmental disabilities also ranked high: residential service providers (96%), sheltered workshops (81%), school districts (74%) and the DACs mentioned above.

Cooperation with social security and local rehabilitation personnel ranked 61% (moderate to much) which might reflect the percentage of clients eligible for this service.

Of those agencies which were ranked lower on the scale in terms of cooperative relationships, criminal justice (46%) referrals and joint efforts may not have been an issue for most directors.

Residential providers were indicated as the group where both the highest level of cooperative work exists, as well as the target for cooperation at the highest (100%) level under "what should be" (see Table 12). Directors as a group indicated that the degree of cooperation from existing levels could be improved with all agencies listed.

Effectiveness of Case Management by Function

Directors were asked to respond to a set of questions designed to determine the efficacy of case management in their agency by each of the common duties or functions of a case manager.

The majority felt that intake, assessment, coordination, and advocacy functions were effectively accomplished. Table 15, Effectiveness of Case Management Service Delivery by Function, illustrates the results. Planning, preparing the individual habilitation plan (IHP), recordkeeping, support, linking and brokering, follow-up, discharge, counseling, and

Table 15

Effectiveness of Case Management Service Delivery by Function

	1 Not Effective		2 Slightly Effective		3 Moderately Effective		4 Effective		5 Very Effective		*M*	Standard Deviation
Function	f	%	f	%	f	%	f	%	f	%		
Intake	1	2	1	2	7	12	34	57	17	28	4.08	.78
Assessment	-	-	2	3	18	30	29	48	11	18	3.82	.77
Planning	2	3	4	7	19	32	26	43	9	15	3.60	.94
Coordination	-	-	5	8	16	27	32	53	7	12	3.68	.79
Development of IHP	2	3	8	13	16	27	27	45	7	12	3.48	.98
Recordkeeping	2	3	13	22	22	37	18	30	5	8	3.18	.98
Support	-	-	4	7	25	42	24	40	7	12	3.57	.79
Linking and Brokering	-	-	7	12	16	27	31	52	6	10	3.60	.83
Monitoring/Follow-up	-	-	9	15	27	45	21	35	3	5	3.30	.79
Discharge	1	2	10	17	21	35	24	40	4	7	3.33	.90
Advocacy	-	-	3	5	12	20	31	53	13	22	3.92	.79
Counseling	1	2	7	12	18	31	26	44	7	12	3.53	.92
Overall Effectiveness	-	-	2	3	24	41	30	51	3	5	3.58	.65

Note: N = 60
VC = 60

overall effectiveness of case management in the agency were considered less effective, ranging from lows of 38% and 40% reporting these areas as effective (recordkeeping and monitoring/follow-up) to 58% reporting "effective" to "very effective" in planning.

An open-ended question regarding gaps in service was asked. A wide range of responses was gained with system problems appearing to be most common.

With 78% of the directors responding to a question which asked about areas of duplication of services in the case management system, the most common response (24%) was that there was no duplication in service.

The number of times per year that case managers in the agency are evaluated was asked of the directors with 82% responding. The most common answer was that evaluation was conducted annually with 75% of the valid cases responding.

The criteria and performance standards used for evaluation of case managers varied, but the most common responses were: (1) use of a job description and merit forms and (2) measuring against individual goals, objectives, and performance indicators.

When asked if the case management system in the county was evaluated for effectiveness, 43% of the 54 valid cases indicated "yes," while 57% said that no county evaluation was conducted.

To determine when staff turnover appeared to be a problem in delivering case management services, directors were asked if the 1986 calendar year's turnover rate was high enough to be a barrier. Of the 58 valid cases, 90% indicated that turnover was not a problem.

When asked what other agencies or professionals perform case management services in the county of the director, 59 of the 60 directors responded, with the bulk of responses (42.4%) indicating that no other agency provided this service.

The last question on the survey asked if the State of Minnesota should apply for Medical Assistance Funding for case management under the Consolidated Omnibus Budget Reconciliation Act. Of the 60 directors, 58 responded with 95% indicating "yes" that the State should apply.

Case Manager Supervisors

Education and Background

Case manager supervisors working in county welfare and human service agencies were asked to identify their educational background in terms of their academic major and their degree. Forty-four of the 59 supervisors responded to this question, with over half reporting a social work major, eight of them reporting a psychology major, and nine supervisors reporting a sociology major. Reporting on their highest educational degree, supervisors responded; 56%, reported that their highest degree was a baccalaureate degree, and 44% reported a master's degree as their highest educational degree.

Supervisors were asked whether they had been county case managers before they became case manager supervisors. Table 16 illustrates the results. Of the 58 respondents 72% indicated that they had been county case managers before becoming case manager supervisors.

Supervisors were asked whether they had taken any college courses which provided training in case management. Of the 37 supervisors responding to this question, most (91.8%) indicated that they had had no courses before becoming employed as case manager supervisors. Of the 59 supervisors, 61% responded to the question of college courses providing training in case management after employment as a case manager supervisor; most (86%) indicated that they had had no college training in case management after their employment as case manager supervisors. Supervisors were then asked about specific college courses they had taken in the field of developmental disabilities, both before and after their employment as case manager supervisors (see Table 17). Of the 36 supervisors who responded to this question, 22 or 61%, indicated that they had had no college courses in the field of developmental disabilities before they became a case manager supervisor. Over one third of the reporting supervisors (38.7%) indicated that they had had at least one course in developmental disabilities before they became a case manager supervisor. Thirty-three of the 34 supervisors who

Table 16

Number of College Courses Taken in Case Management and Year Attended Before and After Employment for Case Management Supervisors

Before Employment:

Number of Courses	f	%	VC	MC
0	34	91	37	22
3	1	3		
6	1	3		
7	1	3		

Courses Taken Prior to 1969	f	%	VC	MC
0	36	97	37	22
7	1	3		
Courses Taken Between 1979-80				
0	36	97	37	22
2	1	3		
Courses Taken in 1981 - present				
0	35	94	37	22
1	1	3		
6	1	3		

After Employment:

Number of Courses	f	%	VC	MC
0	31	85	36	25
1	2	6		
2	2	6		
3	2	3		

Courses Taken Prior to 1969	f	%	VC	MC
0	36	100	36	23
Courses Taken Between 1970-80				
0	35	97	36	23
1	1	3		
Courses Taken in 1981 - present				
0	32	88	36	23
1	1	3		
2	1	6		
3	1	3		

Note. N = 59

VC = valid cases. MC = missing cases.

Table 17

Number of College Courses Taken in Developmental Disabilities and Year Attended Before and After Employment for Case Management Supervisors

Before Employment:

Courses Taken < 1969	f	%	VC	MC	Number of Courses	f	%	VC	MC
0	27	85	32	27	0	22	61	36	23
1	2	6			1	7	19		
2	2	6			2	5	18		
6	1	3			3	1	3		
					6	1	3		
Courses Taken < 1979-80									
0	23	88	32	27					
1	2	6							
2	2	6							
Courses Taken > 1981									
0	31	97	32	27					
2	1	3							

After Employment:

Courses Taken < to 1969	f	%	VC	MC	Number of Courses	f	%	VC	MC
0	34	100	34	25	0	33	97	34	25
					1	1	3		
Courses Taken < 1970-80									
0	33	97	34	25					
1	1	3							
Courses Taken in < 1981									
0	34	100	34	25					

Note. N = 59. VC = valid cases. MC = missing cases.

responded indicated that they had no courses in developmental disabilities since becoming a case manager supervisor.

Case manager supervisors were then asked about inservice training experiences, both in case management and mental retardation (see Table 18). Of the 31 supervisors who responded to this question, 16% (five) indicated that they had had no inservice training in case management or mental retardation, while 84% (26) indicated that they had inservice training experiences in these areas. The number of inservice training experiences of each supervisor ranged from a low of 0 to a high of 14, with the average number of inservice experiences being three. The majority of these inservice training sessions were taken by supervisors between the years of 1981 and 1987.

Staffing Patterns

Case manager supervisors were asked how many years they had been in that position and in what settings. Case manager supervisors reported having spent from one month to 27.5 years in the case manager supervisor position, with the average being over six years. Table 19 shows the results. Of the 55 case manager supervisors responding to this question, all reported working in a county setting.

In response to the question concerning number of case manager supervisors working in the agency, 54 of the 59 supervisors (67%) indicated that their agency had one supervisor. The other 18 supervisors reported a range between two and seven case manager supervisors working in their agency. Table 20, Agency Case Manager Supervisors: Current and Recommended Staffing Patterns, describes the results. Supervisors were then asked how many case manager supervisors they thought there should be. Responses ranged from zero to 14, with an average about two case manager supervisors in the agency.

When asked a question about the average number of case managers assigned to the supervisor, they responded with a range from one to 16, with the mean being about 5.5 case managers to a supervisor. Table 21 shows the results.

Table 18

Number of Inservice Training Experiences in Case Management and Year Attended for Case Management Supervisor

Courses Taken < 1969	f	%	VC	MC	Number of Courses	f	%	VC	MC
0	26	96	27	32	0	5	16	31	28
1	1	4			1	5	16		
					2	8	26		
Courses Taken > 1979-80					3	2	6		
0	23	85	27	32	4	4	13		
1	1	4			5	2	6		
2	2	7			6	2	6		
3	0	0			7	1	1		
4	1	4			8	1	1		
					9	0	0		
					10	0	0		
Courses Taken > 1981					11	0	0		
0	6	21	29	30	12	0	0		
1	6	21			13	0	0		
2	6	24			14	1	3		
3	7	3							
4	2	7							
5	1	3							
6	2	7							
7	2	7							
8	1	3							
9	0	0							
10	0	0							
11	0	0							
12	0	0							
13	0	0							
14	1	1							

Note. N = 59

Table 19

Years as a Case Manager Supervisor by Frequency and Percentage

Years	Frequency	Percentage	M	S.D.	VC
0	6	11	6.23	6.47	55
1	6	11			
2	9	17			
3	7	12			
4	4	7			
5	2	4			
6	4	7			
7	2	4			
8	3	5			
9	0	0			
10	0	0			
11	1	2			
12	0	0			
13	1	2			
14	3	5			
15	2	4			
16-20	3	5			
21-25	1	2			
26-30	1	2			

Note. N = 59

Table 20

Agency Case Manager Supervisors: Current and Recommended Staffing Patterns

What Exists:					What is Recommended:				
Number of Case Manager Supervisors	f	%	M	S.D.	Number of Case Manager Supervisors	f	%	M	S.D.
1	36	67	1.87	1.52	0	1	1.9	2.17	2.36
2	5	9			1	28	52.8		
3	4	7			2	13	24.5		
4	6	11			3	3	5.7		
5	1	2			4	4	7.5		
7	2	4			6	2	3.8		
					10	1	1.9		
					14	1	1.9		

Note. N = 59

Valid cases = 54
Missing cases = 5

Valid cases = 53
Missing cases = 6

Table 21

Average Number of Case Managers Assigned to a Supervisor by Frequency and Percentage

Number	Frequency	Percentage	*M*	S.D.
1	8	14	5.59	3.83
2	10	17		
3	7	12		
4	1	2		
5	5	8		
6	4	7		
7	6	10		
8	4	7		
9	4	7		
10	4	7		
11	1	2		
12	3	5		
13	0	0		
14	0	0		
15	1	2		
16	2	3		

Note. N = 59

Supervisors were asked if they also carried a client caseload in addition to supervisory duties. All supervisors responded, with 17% reporting that they did carry a client caseload and 83% that they did not. Of those supervisors indicating that they carried a caseload, 15 supervisors reported a typical caseload ranged from one to 95 with a mean of over 37 clients. Table 22 shows the results. Over half of the respondents had caseloads of 1 to 15 clients. The exceptionally wide range is shown in the high variance.

Extent of Service Provided

Supervisors were also asked whether or not case management services were provided to all persons with mental retardation or other related conditions which met their agency's criteria for service. Of the 59 supervisors responding to the survey, 57 answered this question, with 84% responding "yes" and 16% responding "no." When asked whether their agency had a waiting list for person with mental retardation or other related conditions who were in need of case management services, all 59 supervisors answered this question, with 12% reporting that they did have a waiting list and 88% reporting that they did not have such a waiting list. A follow-up question to those who responding affirmatively asked whether or not those persons on the waiting list were presently provided with interim services outside of the case management system. Ten supervisors responded to this question, though only seven had stated that they had a waiting list. Seven of those responding said that they did have interim services for persons on a waiting list and three reported that they did not provide interim services.

Barriers

Supervisors were asked to respond to a list of factors which were suggested as possible barriers to the successful delivery of case management services using a Likert scale from 1 (low) to 5 (high). Table 23 provides a more detailed look at the ratings of the possible factors which might affect the delivery of case management services. The factor which received the highest mean score, and likely the most frequent barrier to the

Table 22

Client Caseload Size for Case Manager Supervisors by Frequency and Percentage

Size of Client Caseload	f	%	Mean	S.D.
1 - 5	6	40	37.27	34.85
6 - 10	1	7		
11 - 15	1	7		
16 - 20	0	0		
21 - 25	0	0		
26 - 30	0	0		
31 - 35	1	7		
36 - 80	1	7		
41 - 45	1	7		
46 - 50	0	0		
51 - 60	1	7		
61 - 70	0	0		
71 - 80	0	0		
81 - 90	2	13		
91 - 100	1	7		

Note. N = 59
Valid cases = 15

Table 23

Barriers Rated by Frequency and Percentage

	1 Never a Barrier		2 Seldom a Barrier		3 Often a a Barrier		4 Almost Always a Barrier		5 Always a Barrier				
Barriers	f	%	f	%	f	%	f	%	f	%	M	SD	VC
Client Level of Disability	10	17	32	55	14	24	2	4	0	0	2.12	0.74	58
Service Providers	2	3	37	64	18	31	1	2	0	0	2.14	0.57	58
Lack of Experience of Case Manager	8	14	34	60	18	29	1	2	0	0	2.14	0.67	57
Lack of Family Involvement	1	2	35	60	22	38	0	0	0	0	2.36	0.52	58
Interaction with Other Agencies	8	14	37	64	10	17	1	2	2	3	2.17	0.82	58
Distance to Client Residence	2	3	30	52	16	28	7	12	3	5	2.64	0.93	58
Caseload Size	2	3	5	9	22	33	9	16	20	34	3.69	1.14	58
Amount of Paperwork	1	2	0	0	12	21	18	38	27	47	4.21	0.89	58
Amount of Meetings	0	0	11	19	22	38	15	26	10	17	3.41	0.99	58
Other	0	0	0	0	2	18	3	27	6	55	4.00	--	12

Note. N = 59

delivery of case management services was the amount of paperwork required of case managers, with the mean of 4.2. Next on the list in terms of most likely to be a barrier was case managers' current caseload size with a mean of 3.69. Number of meetings case managers are required to attend was next with a mean of 3.41. Those factors considered by case manager supervisors least likely (seldom-never) to be barriers to effective case management were: interaction with other agencies (78%), client level of disability (75%), lack of case manager experience (74%), service providers (67%), and lack of family involvement (62%).

Supervisors were also given a choice of three staffing factors which might contribute to decreased efficiency in case management activities, and the one found to be most likely a barrier was that of staff shortages, with a mean of 3.39 ranked in "often to "almost always" categories (see Table 24). Under availability of programs, the lack of day program options received the highest mean score at 2.95 ("often a barrier"). In considering funding barriers, the factor of insufficient funds ranked highest (see Table 25). Restrictions in the use of funds also received a relatively high score with a mean of 3.52. County administration did not include any factors which received a mean higher than 2.18 (see Table 25). Inter-agency administration likewise did not have many variables which scored highly, its highest mean score being that of multiple individual plans for a single client with a mean of 2.37 (see Table 26).

When supervisors were asked if their case management turnover rate was high enough to be considered a barrier to effective case management services, 93% of the 56 respondents felt that this was a barrier. When asked what could be done to reduce those case management turnovers, 72% of the 43 respondents indicated that less paperwork would be of help, while 13.9% mentioned that lowering the staff-to-caseload ratio to 1 to 55 or 1 to 60 would make a positive difference.

Table 24

Barriers Rated by Frequency and Percentage: Staffing and Program Availability

	1 Never a Barrier		2 Seldom a Barrier		3 Often a a Barrier		4 Almost Always a Barrier		5 Always a Barrier				
Issue	f	%	f	%	f	%	f	%	f	%	M	SD	VC
Staffing													
Staff shortages	3	4	13	23	18	25	13	23	14	25	3.39	1.24	57
Staff turnover	7	12	33	58	13	23	3	5	1	2	2.26	0.81	57
Layoffs of staff	28	52	21	39	2	4	1	2	2	4	1.64	0.95	55
Program Availability													
Lack of Residential Program Options	2	3	21	37	20	34	10	17	5	9	2.91	1.01	58
Lack of Day Program Options	2	3	19	33	22	38	10	18	5	9	2.95	0.99	58
Lack of other Service Options	1	2	20	34	24	41	12	21	1	2	2.86	0.83	58
Difficult Access for Clients to Services	4	7	33	57	11	19	8	18	2	3	2.50	0.98	58

Note. N = 59

Table 25

Opinions Regarding Barriers to Delivery of Case Management Services by Frequency and Percentage: Funding and County Administration

	1 Never a barrier		2 Seldom a barrier		3 Often a barrier (50)%		4 Almost always a barrier		5 Always a barrier		*M*	Standard Deviation	Valid Cases
Issue:	f	%	f	%	f	%	f	%	f	%			
Funding													
Insufficient funds	2	4	11	20	12	21	14	25	17	30	3.39	1.22	56
Delays in receiving funds for client services	5	9	24	43	15	27	6	11	6	11	2.71	1.12	56
Restrictions in use of funds	14	25	36	65	5	9	-	-	-	-	1.84	.57	55
County Administration													
Lack of routine planning and coordination within own agency	8	14	33	59	13	23	1	2	1	2	2.18	.5	56
Coordination between program units	9	16	26	64	11	20	-	-	-	-	2.04	.6	56
Internal reorganization	14	25	25	65	5	9	-	-	-	-	1.84	.57	55

Note. N = 59

Table 26

Barriers Rated by Frequency and Percentage: Interagency Coordination

	1 Never a Barrier		2 Seldom a Barrier		3 Often a a Barrier		4 Almost Always a Barrier		5 Always a Barrier				
Barriers	f	%	f	%	f	%	f	%	f	%	M	SD	VC
Lack of routine planning	4	7	40	73	11	20	0	0	0	0	2.12	0.51	56
Difficulty in communication	5	8	39	70	10	18	2	4	0	0	2.16	0.62	56
Confidentiality issues inhibiting flow of information	9	16	40	71	6	11	1	2	0	0	1.92	0.59	56
Lack of information concerning other agencies	5	9	38	68	13	23	0	0	0	0	2.14	0.55	56
Inappropriate referrals	10	18	41	73	4	7	0	0	1	2	1.95	0.64	56
Duplication of services	8	14	42	75	5	9	0	0	1	2	2.00	0.63	56
Multiple individual plans for a single client	8	14	27	48	14	25	6	11	1	2	2.37	0.93	56
Clients falling into "cracks" between agencies	2	4	38	67	11	20	4	7	1	2	2.36	0.75	56
Lack of understanding of agency responsibility	11	20	32	57	8	14	4	7	1	2	2.14	0.88	56
Multiple case managers for a single client	8	14	34	61	10	18	8	7	0	0	2.12	0.75	56

Note. N = 59

Cooperative Work Between Agencies

Next, supervisors were asked to indicate the degree of cooperative work between their agencies and those of other agencies in their area using a four-point Likert scale rating from one (1), meaning no cooperative work to four (4), meaning much cooperative work. Supervisors were asked to rate what currently exists, and then indicate what they think should ideally exist. Table 27 provides specific ratings in these categories as indicated by the supervisors. The supervisors reported the most cooperative work between their agencies and the Developmental Achievement Centers (DACs), residential providers and sheltered workshops. Supervisors indicated that they would like to see much more cooperation between their agencies and almost all of the other agencies.

Effectiveness of Case Management by Function

Supervisors were provided with a list of twelve case management functions which were derived from Rule 185. They were asked to rate the effectiveness of case management service delivery provided by their agency for each of these service functions using a Likert scale of one to five, with one (1) being "not effective" and five (5) being "very effective." Table 28 provides a detailed breakdown of these ratings. The average ratings for each of the twelve functions ranged from a low of 3.26 for recordkeeping to a high of 4.26 for intake services. The supervisors' ratings of overall effectiveness produced a mean of 3.91 with a range of ratings from two to five. Over half of the supervisors rated the case management services as 4.0, or effective. Intake, assessment, and advocacy were rated the most effective of the functions provided by the case management system. Recordkeeping and monitoring were among the lowest ranked, though still considered by the majority to be at least moderatively effective.

Gaps and Duplications

Supervisors were asked what gaps they see in their case management system for people with mental retardation or other related conditions with 50 responding. The gap most frequently named in the case management system was a caseload size being too

Table 27

Degree Ratings of Cooperative Work with Other Agencies: Existing and Ideal

Degree of Cooperative Work	Existing None-1		Slight-2		Moderate-3		Much-4		M	SD	VC	Ideal None-1		Slight-2		Moderate-3		Much-4		M	SD	VC
	f	%	f	%	f	%	f	%				f	%	f	%	f	%	f	%			
Department of Services	4	8	14	26	24	45	11	21	2.79	2.85	53	0	0	2	4	4	8	45	88	3.84	0.46	51
School District(s)	0	0	14	25	32	57	10	18	2.92	0.66	56	0	0	2	3	12	23	39	74	3.70	0.54	53
Local Office of Rehabilitation Services	0	0	16	30	29	55	8	15	2.85	0.66	53	0	0	1	2	15	29	35	69	3.67	0.52	51
Mental Health Centers	3	6	8	15	32	59	11	20	2.95	0.76	54	1	2	1	2	22	43	27	53	3.47	0.66	51
Criminal Justice System	5	9	28	54	15	28	5	9	2.38	0.79	53	0	0	22	43	18	35	11	22	2.78	0.78	51
DAC	1	2	5	9	19	35	29	54	3.41	0.74	54	0	0	1	2	5	10	45	88	3.86	0.40	51
Residential Provider(s)	0	0	2	4	21	38	32	58	3.54	0.57	55	0	0	0	0	9	17	43	83	3.83	0.38	52
Sheltered Workshops	2	4	9	17	24	46	17	33	3.01	0.81	52	0	0	1	2	13	26	36	72	3.70	0.51	50
Voluntary Advocacy Agencies	7	13	23	44	18	35	4	8	2.36	0.82	52	0	0	10	19	23	44	19	37	3.17	0.73	52
Community Associations	11	21	31	58	8	15	3	6	2.06	0.77	53	1	2	15	30	23	46	11	22	2.88	0.77	50
Social Security	2	4	18	33	28	52	6	11	2.70	0.72	54	0	0	11	21	22	42	19	37	3.15	0.75	52
University	25	52	19	40	3	6	1	2	1.54	0.77	48	9	20	17	38	13	29	6	13	2.33	1.0	45
AVTI	20	41	20	41	7	14	2	4	1.78	0.8	49	5	12	20	43	13	28	8	17	2.5	0.96	41

Note. N = 59

Table 28

Ratings of Effectiveness of Case Management Services by Function

	1 Not Effective		2 Slightly Effective		3 Moderately Effective		4 Effective		5 Very Effective		M	S.D.	VC
Function	f	%	f	%	f	%	f	%	f	%			
Intake	0	0	1	2	9	15	22	38	26	45	4.26	0.79	58
Assessment	0	0	0	0	15	26	19	33	24	41	4.16	0.81	58
Planning	0	0	4	7	16	28	23	39	15	26	3.85	0.89	58
Coordination	0	0	1	2	13	22	33	57	11	19	3.93	0.70	58
Develop IHP	0	0	11	19	18	31	18	31	11	19	3.5	1.01	58
Recordkeeping	1	2	9	15	27	47	14	25	6	11	3.26	0.92	57
Support	1	2	4	7	12	21	22	37	18	32	3.91	0.99	57
Linking and Brokering	0	0	7	12	16	28	24	41	11	19	3.67	0.93	58
Monitoring/ Following Progress	0	0	6	10	28	49	18	31	6	10	3.41	0.82	58
Discharge	1	2	6	11	18	32	23	41	8	14	3.55	0.93	56
Advocacy	1	2	1	2	11	19	26	45	19	33	4.05	0.87	58
Counseling	1	2	4	7	11	19	31	53	11	19	3.81	0.89	58
Overall Effectiveness	0	0	1	2	13	22	34	59	10	17	3.91	0.68	58

Note. N = 59

large (cited 23 times), followed closely by lack of available services, (cited 20 times). Funding problems were identified as causing gaps by 10 of the respondents. Supervisors were then asked what duplication they saw in their case management system. The most common responses were the amount of paperwork (cited nine times), and the individual service plans (ISP) and individual habilitation plans (IHP) duplicating information (eight responses).

Evaluation

In response to a question of how often they evaluate their case managers, supervisors' replies ranged from "annually," (69%), to once weekly, which was reported by one supervisor. Table 29 describes the results. Supervisors were asked what criteria and performance standards were used for this evaluation. The most common responses were individual goals and objectives for performance indicators, job descriptions and merit forms, and/or the outline of Rule 185. Table 30 describes the results. Supervisors could respond to more than one item. Evaluation of supervisors was addressed by asking who evaluates each case manager supervisor. The majority of the responding supervisors indicated that they were evaluated by their agency director. Table 31 illustrates the results.

Training Needs

Lastly, supervisors were asked about their own training needs. A list was provided with a range of topics which they were asked to check if any of these would fulfill a current need for training. Table 32 list the individual training needs and the number of times they were cited by supervisors. The most commonly cited training need for supervisors was learning how to monitor the quality of service to individual clients. The next most frequently checked items were: (a) assisting clients and families to become their own service coordinators and (b) learning methods for negotiating with clients and service providers when the client disagrees with individual service plan components.

Table 29

Frequency of Case Manager Evaluations by Supervisors Per Year

Times Per Year	Frequency	Percentage	*M*	S.D.
1	38	69	4.0	1.22
2	6	10		
4	1	2		
8	1	2		
12	7	13		
24	1	2		
52	1	2		

Note. N = 59
Valid cases = 55

Table 30

Criteria and Performance Standards Used in Evaluating Case Managers by Frequency and Percentage

Standards	Frequency	Percentage
Job description and Merit form	9	15
Outline - Rule 185	8	13
Case Record Service	7	12
Evaluation forms for all workers	3	5
Ongoing supervisory comments	1	2
Individual goals and objective performance indicators	9	15
Division of Human Services - 569 Merit	6	10
Other	19	32

Note. N = 59
Valid Cases = 56

Table 31

Evaluators of Case Manager Supervisors by Frequency and Percentage

Evaluator	Frequency	Percentage
Section Supervisor	6	10
Agency Director	36	63
Social Services Division Director	4	7
Associate Director	1	2
Program Manager	9	16
Board and Director	1	2

Note. N = 59
Valid cases = 57

Table 32

Training Needs Identified by Case Management Supervisors

Area	Frequency	Percentage
Information on history, normalization, values	7	12
How to identify client's personal goal, preferences, strengths, and needs	22	37
Methods for creative problem solving	24	41
Legal rights and protections of clients	22	37
How to assist clients and families in becoming their own service coordinators	27	46
How to relate to and work with other agencies	10	17
Methods to assist and refer clients in crises	12	20
Data use to determine client eligibility	9	15
Identifying pertinent client information	11	18
Using client information to develop an Individual Service Plan	17	29
Brokering	17	29
Methods to facilitate the team consensus process	22	37
How to participate in the Individual Program Plan	10	17
Methods of procuring information related to service options	20	32
Methods for negotiating with clients and service providers when the client disagrees with individual plan components	27	46
How to participate in periodic client reviews	3	5
How to monitor quality of service to individual clients	40	68
General information of developmental disabilities	12	20

Note. N = 59
Valid cases = 57

Case Managers

Case managers in county agencies throughout the state responded to the case management survey. Completed surveys numbered 195.

Education and Training

When asked about the academic major of the case managers, 41% indicated a social work background, and 14%, a sociology major. Table 33 describes the results. The majority of responses to the highest educational degree attained by case managers was a bachelor's degree (85.1% of 195 respondents), with a master's degree held by 11.3%. One case manager had no degree and the remaining had a variety of other backgrounds.

The greatest percentage (80%) of the case managers responding to the survey indicated they had no formal coursework in case management. Table 34 describes the results. Of those who had taken formal coursework, a range of one to four courses had been taken by eight of the case managers prior to 1969. One to eight courses had been taken between 1970 and 1980 by 9.2% of the respondents, and one to four courses were taken between 1981 to the present by 5.4% of the case managers. A similar question was asked regarding coursework in developmental disabilities and 55% reported taking no courses, only 23% taking one or two courses in the area (see Table 35 for complete results).

Regarding inservice training, case managers were asked to list topics of sessions they had previously taken and the year when these were offered. Inservice experiences in case management and developmental disabilities ranged from no sessions to 50. Of the 164 respondents, 88% received most of their inservice training between 1981 and 1987, 12% between 1970 and 1980, and a single respondent had inservice training on these topics prior to 1969. The mean number of inservice sessions for the 1981-1987 group (164 respondents) was 5.5.

Table 33

Educational Background of Case Managers by Academic Major

Educational Majors	Frequency of Response	Percentage of Response
Social Work	74	41
Sociology	25	14
Psychology	17	9
Education	10	6
Criminal Justice	1	1
Other	16	8
No Response	37	21

Note: N = 195
Valid Cases = 180
Missing Cases = 15

Table 34

Number of College Courses Taken in Case Management and Year Attended for Case Managers

Number of Courses	f	%	M	S.D.	VC	MC
0	148	80	.44	1.17	185	10
1	18	10				
2	9	5				
3	4	2				
4	3	2				
6	1	.5				
7	1	.5				
8	1	.5				

Note: N = 195

Courses Taken 1969	f	%	M	S.D.	VC	MC
0	175	96	.08	.43	183	12
1	5	3				
2	1	.5				
3	1	.5				
4	1	.5				
Courses Taken 1970 - 1980						
0	166	90.7	.22	.93	183	12
1	6	3.3				
2	7	3.8				
3	2	1.1				
7	1	.5				
8	1	.5				
Courses Taken 1981 - ff						
0	173	94.6	.09	.45	183	12
1	6	3.3				
2	2	1.1				
3	1	.5				
4	1	.5				

Table 35

Number of College Courses Taken in Developmental Disabilities and Year Attended for Case Managers

Number of Courses	f	%	M	S.D.	VC	MC
0	101	55	1.01	1.72	183	12
1	33	18				
2	27	15				
3	10	5				
4	6	3				
5	2	1				
6	2	1				
7	1	1				
15	1	1				

Courses Taken 1969	f	%	M	S.D.	VC	MC
0	157	87	.2	.6	180	15
1	14	8				
2	6	3				
3	2	1				
4	1	1				
Courses Taken 1970 - 1980						
0	148	82	.36	.96	180	15
1	15	8				
2	8	4				
3	5	3				
4	3	2				
7	1	1				
Courses Taken 1981 - ff						
0	150	83	.4	1.42	180	15
1	15	8				
2	7	4				
3	4	2				
5	2	1				
6	1	1				
15	1	1				

Note: N = 195

Case managers were asked the length of time they had served as a case manager and the type of setting in which they had worked. Results are noted on Table 36. The range was from less than one year to 34 years with an average of over six years experience. Ninety-five percent of the 186 respondents worked in county agencies. A few indicated they had worked in more than one agency.

Another question addressed years of experience in working with persons with mental retardation and other related conditions. The range of responses was from less than one year to 31 years with a mean of over five years. Of the 195 respondents, an overwhelming majority (93%) served persons with developmental disabilities in county agencies.

When asked if the case manager was a qualified mental retardation professional (QMRP), as stipulated in the Medicaid ICF/MR regulations, 73% of the 185 respondents indicated that they were so qualified, 21.6% said that they were not, and 4.9% did not know.

The question of current professional licensure or certification produced a finding that over 85% held no licensure (see Table 37).

In identifying the job titles of 188 respondents, it was found that 97% were called social workers or case mangers, while 2% were case management aides.

Client Population

The next section addressed the number of clients served with developmental disabilities by age group. Generally, the case managers served adults more frequently than school-aged children and youth. Table 38 describes the results.

In an effort to illustrate case managers' actual caseloads of clients with and without developmental disabilities, a detailed breakdown of numbers of clients per case manager is listed on Table 39. The data indicated that the average caseload of clients with and without developmental disabilities is slightly over 68 persons, more than twice

Table 36

Length of Time Employed as Case Manager

Number of Years	Frequency of Response	Percentage of Response	M	S.D.	VC
0	12	7	6.75	6.95	177
1 - 5	86	48			
6 - 10	46	25			
11 - 20	24	14			
21 - 34	9	6			

Note: N = 195

Table 37

Current Professional Licensure or Certification of Case Manager Personnel

Licensure/Certification Type	Frequency of Response	Percentage of Response	VC	MC
None	146	86	170	25
Social Worker	15	9		
Teaching	3	2		
Rehabilitation	1	1		
Other	5	3		

Note: N = 195

Table 38

Number of Clients with Developmental Disabilities Served by Case Managers According to Age Group

Number of Clients	Frequency of Case Manager Response	Percentage of Response	M	S.D.	VC	MC
	Age: Birth to 5 years					
0	93	49	2.48	4.05	188	7
1 - 5	68	37				
6 - 10	19	10				
11 - >	8	4				
	Age: 6 - 21 years					
0	27	14	6.94	7.83	190	5
1 - 5	72	38				
6 - 10	51	27				
11 - 15	24	14				
15 - >	16	7				
	Age: Adults					
0	8	4.2	45.58	26.33	192	3
1 - 20	23	12				
21 - 40	44	22.9				
41 - 60	75	39.1				
60 - >	42	21.8				
	Totals					
1 - 20	17	9	55.01	25.44	192	3
21 - 40	34	18				
41 - 60	73	38				
61 - 90	68	35				

Note: N = 195

Table 39

Number of Clients Served by Human Services Case Managers Including Those with and without Developmental Disabilities

Number of DD Clients	Number of Non-DD Clients	Total	Number of DD Clients	Number of Non-DD Clients	Total	Number of DD Clients	Number of Non-DD Clients	Total
11	5	16	25	15	40	50	0	50
17	0	17	40	0	40	50	0	50
19	0	19	40	0	40	50	0	50
19	0	19	32	10	42	40	10	50
19	2	21	33	9	42	25	26	51
14	10	24	32	12	44	51	0	51
23	4	27	45	0	45	12	40	52
30	0	30	42	3	45	52	0	52
30	1	31	44	1	45	50	2	52
32	1	33	45	0	45	52	0	52
34	0	34	20	25	45	26	26	52
35	0	35	34	12	46	52	0	52
35	0	35	47	0	47	50	2	52
35	0	35	47	0	47	53	0	53
36	0	36	48	0	48	50	3	53
36	0	36	48	0	48	54	0	54
36	0	36	48	0	48	54	0	54
36	0	36	18	30	48	54	0	54
38	0	38*	49	0	49	54	0	54
10	29	39	46	3	49	53	1	54
20	19	39	50	0	50	55	0	55
20	20	40	50	0	50	55	0	55
25	15	40	50	0	50	8	47	55
53	2	55	50	0	50	35	20	55
56	0	56	61	0	61	30	25	55
56	0	56	61	0	61	61	6	67
38	18	56	60	1	61	68	0	68
56	0	56	62	0	61	48	20	68
56	1	57	60	2	62	67	2	69
55	2	57	50	12	62	66	3	69
57	0	57	62	0	62	61	8	69
55	2	57	59	3	62	69	0	69
55	2	57	62	1	63	70	0	70
51	6	57	60	3	63	70	0	70

Table 39 (Continued)

Number of DD Clients	Number of Non-DD Clients	Total	Number of DD Clients	Number of Non-DD Clients	Total	Number of DD Clients	Number of Non-DD Clients	Total
58	0	58	63	0	63	70	0	70
58	0	58	58	5	63	70	0	70
58	0	58	35	30	65	70	0	70
58	0	58	50	15	65	70	0	70
53	5	58	65	0	65	71	0	71
59	0	59	65	0	65	71	0	71
59	0	59	65	0	65	72	0	72
58	1	59	65	0	65	68	5	73
57	2	59	40	25	65	68	5	73
60	0	60	66	0	66	65	8	73
60	0	60	66	0	66	72	1	73
60	0	60	65	2	67	74	0	74
70	5	75	76	10	86	75	0	75
50	25	75	78	10	88	142	0	142
44	31	75	61	28	89	12	140	152
75	1	76	44	45	89	50	103	153
76	0	76	41	50	91	44	120	164
69	7	76	93	0	93	9	171	180
51	25	76	82	11	93	188	1	189
56	20	76	41	55	96	196	0	196
37	40	77	82	14	96	60	140	200
75	3	78	36	61	97	60	181	241
66	12	78	100	0	100			
40	39	79	75	25	100			
79	0	79	100	2	102			
66	14	80	15	89	104			
80	0	80	98	7	105			
80	0	80	103	2	105			
61	20	81	110	0	110			
72	10	82	108	4	112			
14	70	84	90	25	115			
40	45	85	70	40	110			
68	17	85	94	24	118			
66	20	86	75	45	120			
56	30	86						

TOTALS

DD Clients	Non-DD Clients	Total
10,614	2,463	13,077
M = 55.28	M = 12.83	M = 68.11

Note: N = 192 case managers

* Part-time person

the recommended ratio of 1:30. Only eight case managers of the 192 respondents had caseloads of 1:30 or less.

Of the sample of 192 case managers, it was found that 4.4 percent of their client population with developmental disabilities served were children from birth to five years; 12.5 percent were between the ages of 6 and 21 years; and 83% of their clients were adults.

A follow-up question asked the total number of persons with mental retardation or other related conditions (which for purposes of this study will be referred to as "developmental disabilities") who were assigned an IQ score below 35 points. Table 40 illustrates the results. The range was none (0) to 110 clients. Results were fairly evenly distributed with the majority of responses falling in the 11 to 20 clients grouping.

When asked about their client population who may be diagnosed in the profoundly retarded range and also have behavior problems, the majority (67%) dealt with one to ten clients for whom this diagnosis might be characteristic. Table 41 describes the results. Of the client population with IQ scores above 35 who also have significant behavior problems, results were similar to the previous item, namely, that the majority of case managers have one to ten clients for whom these characteristics apply (see Table 42).

Case managers were asked their preference if they could choose the makeup of their caseload. Of the 186 responding, 56% indicated they would prefer that 100% of their caseload of clients be those with mental retardation and other related conditions. Others, (40%), indicated that they would like a combination of clients with such handicaps and others who were not so handicapped. The least number (six case managers) indicated they had no preference (3%).

When asked how many clients with developmental disabilities were dropped from the case manager's caseload in 1986 because services were no longer needed, the majority

Table 40

Clients Served with Developmental Disabilities Having IQ Scores Below 35

Number of Clients	Frequency of Case Manager Response	Percentage of Response	*M*	S.D.	VC	MC
0	2	1	17.97	14.25	188	7
1 - 5	29	15				
6 - 10	29	15				
11 - 15	38	20				
16 - 20	29	15				
21 - 25	20	11				
26 - 30	21	11				
31 - 110	20	11				

Note: N = 195
VC = valid cases
MC = missing cases

Table 41

Clients Served with Developmental Disabilities with IQ Scores Below 35 Having Behavior Problems

Number of Clients	Frequency of Case Manager Response	Percentage of Response	*M*	S.D.	VC	MC
0	15	8	7.73	7.15	183	12
1 - 5	69	38				
6 - 10	54	29				
11 - 15	27	15				
16 - 20	9	5				
21 - 42	9	5				

Note: N = 195
VC = valid cases
MC = missing cases

Table 42

Clients with IQ Scores 35 or Above with Severe Behavior Problems

Number of Clients	Frequency of Case Manager Response	Percentage of Response	*M*	S.D.	VC	MC
0	10	6	8.78	7.04	179	16
1 - 5	59	33				
6 - 10	58	32				
11 - 15	29	17				
16 - 20	13	9				
21 - 50	10	3				

Note: N = 195

indicated that only a small number or none were discharged. Table 43 illustrates the results.

Assessing how long a case manager worked with a given client, the next question divided length of time in periods of year(s) (see Table 44). The highest mean of the year ranges was slightly over 26 clients served for a period of one to five years. At the lower end of the continuum, those who had served clients for over ten years served an average of nearly nine clients for that time period.

The amount of case aide time devoted to assisting the case manager was determined according to full-time equivalents (F.T.E.) from none to one full-time individual. Table 45 illustrates the results. The majority (60%) of case managers had no case management aide assisting them, while 25% received from 1% to 25% time of case management aide time.

Case managers were asked how many clients they had in their caseload who did not have developmental disabilities (see Table 46). A significant percentage (45%) indicated that their caseload was composed totally of individuals with developmental disabilities. However, there was a wide range of responses; one individual indicated that he/she serves 181 clients in addition to those clients with disabilities.

Barriers

The next section of the survey dealt with potential barriers to the delivery of case management services. Each section will be discussed separately and Tables 47-50 describe the results. A variety of problems was listed and the case manager was asked to grade, on a one to five point scale, whether an item was "never a barrier" (1) to "always a barrier" (5). The most significant barrier reported was the amount of paperwork required of case managers, and the least reported problem was the client's level of disability (see Table 47). The current client caseload size and number of required meetings were also noted as relatively serious barriers.

Table 43

Clients With Developmental Disabilities Removed From Caseloads In 1986 When Services Were No Longer Needed

Number of Clients	Frequency of Case Manager Responses	Percentage of Responses	*M*	S.D.	VC	MC
0	103	58	1.1	1.66	177	18
1 - 2	44	25				
3 - 4	19	11				
5 - 6	9	5				
7 - 8	2	1				

Note: N = 195

Table 44

Clients With Developmental Disabilities Currently Served By Length Of Time Served

Number of Clients	Frequency of Case Manager Response	Percentage of Response	M	S.D.	VC	MC
Less than 1 year						
0	31	18	10.0	16.45	176	19
1 - 10	111	63				
11 - 20	14	9				
21 - 93	20	10				
1 - 5 years						
0	27	15	26.18	24.94	180	15
1 - 40	101	56.2				
41 - 80	49	27.1				
81 - 110	3	1.7				
5 - 10 years						
0	84	51	9.1	17.59	165	30
1 - 20	57	34.5				
21 - 40	15	9.1				
41 - 80	8	4.8				
81 - 153	1	.6				
> 10 years						
0	107	66.9	8.91	17.57	160	35
1 - 20	24	15				
21 - 40	19	11.9				
41 - 60	9	5.6				
61 - 125	1	.6				

Note: N = 195

Table 45

Amount of Case Aide Time Provided to Case Manager to Assist with Clients Having Developmental Disabilities

Portion of F.T.E. Case Aide	Frequency of Case Manager Responses	Percentage of Responses	M	S.D.	VC	MC
0	109	59.6	15.94	60.67	183	12
.01 - .25	45	24.6				
.26 - .50	23	12.6				
.51 - 1.00	4	2.2				
1.1 - 2.5	1	.5				
2.6 - 7.5	1	.5				

Note: N = 195

Table 46

Non-disabled Clients Served by Case Manager

Number of Clients	Frequency of Case Manager Response	Percentage of Response	*M*	S.D.	VC	MC
0	86	45.3	12.5	27.96	190	5
1 - 5	40	21.1				
6 - 10	12	6.3				
11 - 15	10	5.2				
16 - 20	9	4.7				
21 - 40	19	10				
41 - 181	14	7.4				

Note: N = 195

Table 47

Opinions Regarding Barriers to Delivery of Case Management Services by Frequency and Percentage

	1 Never a barrier		2 Seldom a barrier		3 Often a barrier (>50%)		4 Almost always a barrier		5 Always a barrier			Standard	Valid
Barriers	f	%	f	%	f	%	f	%	f	%	M	Deviation	Cases
Client's level of disability	47	24	114	59	30	16	1	1	1	1	1.94	.68	193
Service providers	4	2	115	60	64	33	10	5	-	-	2.42	.62	193
Lack of training information	10	5	113	58	54	28	13	7	4	2	2.42	.78	194
Lack of family involvement	6	3	129	67	50	26	8	4	-	-	2.31	.60	193
Degree to which case manager will have to interact with other agencies	2	1	63	32	97	50	27	14	5	3	2.85	.77	194
Travel time/distance to client residence	5	3	95	49	63	33	22	11	7	4	2.64	.86	192
Case manager's current client caseload size	3	2	27	14	47	24	38	20	78	40	3.83	1.15	193
Amount of paperwork required of case managers	-	-	11	6	38	19	68	35	78	40	4.09	.90	195
Number of meetings case managers are required to attend	4	2	65	34	76	39	32	16	17	9	2.96	.97	194

Note: N = 195

The next part of the survey addressed staffing concerns. Reduction in force or lay-offs of case management staff was considered least likely to be a barrier, while staff shortages appeared to be most commonly seen as a barrier (see Table 48).

The section of the survey dealing with availability of programs (also illustrated on Table 48) found that lack of residential program options was the most serious barrier, 14% of respondents rating from "often" to "always." Though apparently excluding residential options, the least problem was gaining access to programs and services.

Under funding issues, insufficient funds was ranked "often" to "always" a barrier by 73% of the case manager respondents; closely following this was restriction in the use of funds (68%) (see Table 49). Delays in receiving funds did not appear to a barrier for at least half of the respondents.

County administration issues such as routine planning, coordination between units and internal reorganization did not appear to pose any serious barriers to provision of case management services (also shown on Table 49).

The section of the survey regarding interagency administration failed to identify any serious barriers to case management services, though approximately 51% indicated that there were clients who "fell between the cracks" in the delivery of services (see Table 50). The one item appearing to be the least problem was inappropriate referrals. From the data it would appear that referring agencies are aware of guidelines for referral and thus, refer appropriate candidates for services.

Client Orientations

Case managers were questioned about their methods of orienting clients and their families to the case management system (see Table 51). It was found that the majority of the case managers orient the client and his/her family to case management services and explain the process. A smaller percentage (39% and 44%, respectively) inform them

Table 48

Opinions Regarding Barriers to Delivery of Case Management Services by Frequency and Percentage: Staffing and Program Availability

Issue:	1 Never a barrier		2 Seldom a barrier		3 Often a barrier (>50%)		4 Almost always a barrier		5 Always a barrier				
Staffing	f	%	f	%	f	%	f	%	f	%	M	Standard Deviation	Valid Cases
Staff shortages	7	4	44	23	44	23	33	17	67	34	3.56	1.27	195
Staff turnover	32	17	108	56	35	18	15	8	2	1	2.2	.85	192
Reduction in force of management staff	107	58	56	30	10	5	4	2	7	4	1.63	.97	184
Program Availability													
Lack of residential program options	3	2	48	25	73	38	49	25	21	11	3.19	.98	194
Lack of day program options	2	1	57	30	87	45	32	17	15	8	3.0	.90	193
Lack of other program/ service options	-	-	55	28	99	51	24	12	16	8	3.0	.86	194
Difficult access for program/services	5	3	82	43	66	34	26	14	13	7	2.8	.95	192

Note: N = 195

Table 49

Opinions Regarding Barriers to Delivery of Case Management Services by Frequency and Percentage: Funding and County Administration

Issue:	1 Never a barrier		2 Seldom a barrier		3 Often a barrier (>50%)		4 Almost always a barrier		5 Always a barrier				
Funding	f	%	f	%	f	%	f	%	f	%	M	Standard Deviation	Valid Cases
Insufficient funds	4	2	46	25	67	36	48	26	20	11	3.18	1.0	185
Delays in receiving funds for client services	8	4	84	46	46	25	34	19	10	5	2.75	.99	182
Restrictions in use of funds	3	2	56	30	62	33	42	23	23	12	3.14	1.0	186
County Administration													
Lack of routine planning and coordination within one agency	15	8	87	47	49	26	19	10	15	8	2.63	1.04	185
Coordination between program units	23	12	106	57	38	21	10	5	8	4	2.32	.92	185
Internal reorganization	27	15	103	56	35	19	12	7	7	4	2.29	.93	184

Note: N = 195

Table 50

Opinions Regarding Barriers to Delivery of Case Management Services by Frequency and Percentage: Interagency Administration

	1 Never a barrier		2 Seldom a barrier		3 Often a barrier (>50%)		4 Almost always a barrier		5 Always a barrier				
Barriers	f	%	f	%	f	%	f	%	f	%	M	Standard Deviation	Valid Cases
Lack of routine planning and coordination	16	9	114	61	46	25	7	4	3	2	2.29	.74	186
Difficulty in communications	15	8	124	67	34	18	10	5	1	1	2.22	.71	185
Confidentiality issues	21	11	133	71	27	14	4	2	3	2	2.12	.69	188
Lack of understanding about resources	15	8	112	60	51	27	7	4	1	1	2.29	.69	186
Inappropriate referrals	35	19	139	76	5	3	5	3	-	-	1.89	.56	184
Duplication of services	24	13	134	72	23	12	4	2	-	-	2.04	.58	185
Multiple individual plans for a single client	19	10	107	58	42	23	12	6	6	3	2.35	.87	186
Clients "falling into the cracks" between agencies	9	5	83	44	75	40	18	10	2	1	2.58	.78	187
Lack of clear understanding of which agency is responsible for client's case management	30	16	119	64	31	17	7	4	-	-	2.08	.69	187
Multiple case managers/ client coordinators for a single client	32	17	114	61	30	16	9	5	1	1	2.10	.75	186

Note: N = 195

Table 51

Method of Orienting Client to Case Management Services and Process

Method	Frequency Yes	Frequency No	Percentage Yes	Percentage No	Valid Cases	Missing Cases
Orient client/families to case management services	151	35	81	19	186	9
Explain case management process	124	59	68	32	183	12
Inform regarding opportunity to request another case manager if dissatisfied	71	113	39	61	184	11
Contact them prior to service plan review meeting	80	98	44	54	180	15

Note: N = 195

of the opportunity to gain a new case manager if dissatisfied or to contact them before the review meeting.

Case managers were asked how important they feel it is for the client to participate in the individual service plan (ISP) meeting. Of the 181 respondents, 82% considered this participation very important. Of the remainder, 17% indicated that it was somewhat important and 1% felt that it was not important to include the client.

When asked how often consensus is reached at the end of the service plan reviews in which the case manager participates, 72% indicated that consensus was always reached, while 27% indicated that it was sometimes reached.

Case Manager Responsibilities

A list of responsibility statements was presented to the case managers (see Table 52). They were asked whether these were current responsibilities and if these responsibilities should be undertaken by the case manager. Significantly high percentages were characteristic of all five responsibility statements under "current" and what "should be" the case manager's responsibility. The highest percentage fell under "ensuring that the service plan review meeting is held."

Two questions were asked regarding the clients and their parents or guardians taking an active role in procuring, adapting, and arranging the services identified in the individual service plan. The first question addressed the client/family's level of knowledge about the subject, and the second addressed the level of involvement in procuring services. Table 53 shows that the majority of responses (87%) fell between "sometimes" (3) and "always" (5), while the smallest percentage (13%) indicated that they were "seldom" or "never" aware of their rights in taking an active role in gaining services. Table 54 showed that 58% of the clients or their guardians "sometimes" to "always" taken an active role in gaining services. What the data showed are that clients, parents, and guardians may have the information about their rights to be their own case

Table 52

Responsibilities of Case Managers Serving Persons with Developmental Disabilities

	Current Case Manager Responsibility:						Should Be Case Manager Responsibility:					
	Frequency		Percentage				Frequency		Percentage			
Responsibility Statement	Yes	No	Yes	No	VC	MC	Yes	No	Yes	No	VC	MC
Ensure that the service plan review meeting is held	188	0	100	0	188	7	158	5	97	3	163	32
Ensure that plan update is jointly developed	162	21	89	11	183	12	140	25	85	15	165	30
Ensure that client's views are heard and integrated into plan	175	8	96	4	183	12	156	8	95	5	164	31
Advocate for client when he/she disagrees with team	164	17	91	9	188	7	133	25	84	16	165	30
Write the plan document and distribute it to client and team members	152	29	84	16	181	14	133	32	81	19	158	37

Note: N = 195

Table 53

Clients/Parents/Guardians' Level of Knowledge on Role in Service Planning: That They May Arrange Services in ISP

Probe	Frequency of Case Manager Response	Percentage of Response	M	S.D.	VC	MC
Never	8	1	3.6	.90	188	7
Seldom	22	12				
Sometimes	56	30				
Usually	81	42				
Always	28	15				

Note: N = 195

Table 54

Level of Involvement of Clients/Parents/Guardians in Service Planning

Probe	Frequency of Case Manager Response	Percentage of Response	M	S.D.	VC	MC
Never	8	4	2.7	.81	188	7
Seldom	71	38				
Sometimes	80	43				
Usually	27	14				
Always	2	1				

Note: N = 195

manager, but they may not exercise this right or feel they do not have the skills or time to do so.

Six options were given the case managers regarding the procedures they use to monitor the progress of the service plan (see Table 55). The procedure with the highest percentage (97%) was holding an annual review. The lowest ranked, but still with a majority of the case managers responding in the affirmative, was holding periodic family interviews.

When asked what procedures are used when the service is not available to the client, the two highest ranked choices were: (a) recommending appropriate alternatives, and (b) writing the need into the ISP (see Table 56). Postponing writing the need into the ISP or waiting until the annual meeting were rejected by most case managers as options that were not viable, knowing that the client's best interest would not be met by using such "wait and see" procedures.

The percentage of time spent on case management showed a wide range of responses from 5% to 100% of the time (see Table 57). However, 73% of the responses fell within the range of 71 - 100% of the total time the case manager spent on the job.

The next section listed case management functions (see Table 58). Case managers were asked if they typically performed these functions, and if "yes," what percentage of their time was devoted monthly to each. The majority (60%) responded that all of these functions were typical of their duties with intake being the least time-consuming (60%). This may be due to the assignment of intake responsibilities to a specific person in the agency. The highest mean percentage of time was devoted to developing the IHP (18.32%) and secondly to recordkeeping (17.62% per month), and the lowest percentages of time were devoted to intake and discharge responsibilities.

Table 55

Procedures Employed by Case Managers to Monitor Progress of the Service Plan

Procedure	Frequency Yes	Frequency No	Percentage Yes	Percentage No	VC	MC
Visit client at service sites while services are being provided	176	16	92	8	192	3
Review service providers' records and reports	165	28	85	15	193	2
Hold periodic client interviews	157	33	83	17	190	5
Hold periodic family interviews	121	68	64	36	189	6
Hold annual review meeting	189	5	97	3	194	1
Revise individual service and habilitation plans as needed	181	11	94	6	192	3

Note: N = 195

Table 56

Procedures Employed by Case Managers When Service is Unavailable to Client

Procedure	Frequency Yes	Frequency No	Percentage Yes	Percentage No	Valid Cases	Missing Cases
Write the need into the individual service plan (ISP)	182	11	94	6	193	2
Postpone writing need into ISP until services are available	12	176	6	94	188	7
Recommend appropriate alternatives	180	9	95	5	189	6
Set date to review alternative service needs	121	67	64	36	188	7
Assign someone to develop needed services	117	64	65	35	181	14
Notify proper authorities of gap in services	162	28	85	15	190	5
Wait until annual review meeting	44	140	24	76	184	11
Schedule a review meeting	124	60	67	33	184	11

Note: N = 195

Table 57

Reported Percentage of Time Spent on Case Management

Percentage of Time	Frequency of Case Managers Response	Percentage of Response	M	S.D.	VC	MC
0 - 10	3	2	75.22	22.35	175	20
11 - 20	2	1				
21 - 30	9	5				
31 - 40	6	3				
41 - 50	13	7				
51 - 60	6	3				
61 - 70	11	6				
71 - 80	52	30				
81 - 90	33	19				
91 - 100	40	24				

Note: N = 195

Table 58

Case Management Functions Performed by Case Managers and Estimated Monthly Percentage of Time Spent Per Function

	Frequency		Percentage			Range of Estimated Percentage of Time Per Function	$\underline{M}$ of Percentage of Time Per Function	S.D. of time Per Function	Valid Cases
Function Performed	Yes	No	Yes	No	VC				
Intake	110	72	60	40	182	0 - 10	2.36	2.5	176
Assessment	176	5	97	3	181	0 - 30	7.72	4.85	183
Planning	179	1	99	1	180	0 - 50	12.74	7.95	181
Coordination	179	2	99	1	181	0 - 50	14.33	9.24	182
Develop IHP	140	38	79	21	178	0 - 30	18.32	6.64	178
Recordkeeping	177	3	98	2	180	0 - 65	17.62	11.61	182
Support	175	4	98	2	179	0 - 35	7.6	6.08	182
Linking and Brokering	156	14	92	8	170	0 - 25	7.09	5.62	181
Monitoring/ Follow-Up	166	3	98	2	169	0 - 25	9.08	5.24	180
Discharge	142	24	86	14	166	0 - 10	2.43	1.8	169
Advocacy	161	8	95	5	169	0 - 20	4.88	3.42	181
Counseling	158	9	95	5	167	0 - 30	5.4	3.92	181

Note: N = 195
VC = Valid Cases

Effectiveness

Twelve case management functions were listed with each item rated by overall effectiveness of the case management delivery system (see Table 59). Case managers rated these on a five-point scale. Those functions ranking the most effective were support and advocacy functions, while the one ranking lowest was development of the IHP. All other functions were rated in the moderately effective to effective range, indicating a fairly high level of satisfaction with the system.

Training Needs

In response to an item which listed potential training need topics, the case managers marked the following as most necessary: (a) methods for negotiating with clients and service providers when there is a disagreement, (b) methods for creative problem-solving and for thinking innovatively, (c) how to develop an individual habilitation plan, (d) methods for procuring accurate information related to service options, and (e) how to assist clients in becoming their own case manager. The item least frequently marked was information on history, normalization and values. The number of respondents ranged from 29 to 108 depending upon the item.

Gaps in service and duplication in service items had a low response and, generally, those who responded repeated information covered in other parts of the survey.

Summary

Education and Training

The majority of case managers and case manager supervisors had taken no college courses in case management. In the field of developmental disabilities, 61% of the supervisors and 55% of the case managers had no coursework in the area. Inservice experience in case management and developmental disabilities showed more favorable results with 84% of the supervisors and 88% of the case managers having received

Table 59

Effectiveness of Case Management Service Delivery by Function

Function	1 Not Effective f	%	2 Slightly Effective f	%	3 Moderately Effective (>50%) f	%	4 Effective f	%	5 Very Effective f	%	M	Standard Deviation	Valid Cases
Intake	12	7	13	8	47	29	67	41	23	14	3.47	1.07	162
Assessment	4	2	11	6	62	33	89	48	20	11	3.59	.84	186
Planning	4	2	11	6	63	34	85	46	23	12	3.60	.86	186
Coordination	4	2	11	6	63	34	85	46	23	12	3.60	.86	186
Development of IHP	15	9	34	20	69	40	46	27	7	4	2.98	.99	171
Recordkeeping	7	4	37	20	64	34	56	30	23	12	3.27	1.04	187
Support	1	1	10	5	45	24	98	52	34	18	3.82	.81	188
Linking and Brokering	5	3	18	10	71	39	64	35	26	14	3.48	.95	184
Monitoring/Follow-Up	2	1	29	16	69	37	70	38	16	9	3.37	.89	186
Discharge	5	3	23	13	55	30	73	40	26	14	3.51	.98	182
Advocacy	1	1	8	4	51	28	84	46	40	22	3.84	.83	184
Counseling	3	2	12	7	56	30	88	48	25	14	3.65	.86	184
Overall Effectiveness	1	1	6	3	61	34	97	54	14	8	3.63	.75	180

Note: N = 195

training in these areas. For the majority of case managers, these inservice sessions were taken between 1981 and 1987.

Staffing Patterns

Of the director respondents, 88% reported that there were no (0) case manager supervisors to one full-time supervisor in the county human services agency. Over half of the Minnesota counties reported one to two case managers per agency with larger counties reporting up to 44 case managers. Supervisors reported an average of over five case managers assigned to each supervisor with a range of 1 to 16 case managers per supervisor. Of the responding supervisors, 17% carried a caseload in addition to their supervisory duties. The mean number of clients for these supervisors was 37.

One of the most significant findings of the study was that the average caseload of a case manager was over 68 clients with and without developmental disabilities, a ratio over twice that recommended for effective case management.

Regarding the use of case management aides in the counties, 83% of the directors indicated that either no case aide or only one was employed by the agency. The majority of case managers reported having no service from a case management aide and those who did, commanded only a small portion of the case management aide's time.

Barriers to Effective Case Management

Interestingly, directors, case manager supervisors, and case managers reported the most serious barriers to effective case management were the amount of paperwork required, the heavy caseloads, and the number of meetings required.

The majority of directors, supervisors, and case managers reported that staff shortages were a serious hindrance to effective case management.

Directors and supervisors identified lack of program or service options as a serious barrier, while case managers reported lack of residential services for clients in need as a problem.

Insufficient funds was noted as a serious barrier by directors, supervisors, and case managers, with supervisors also reporting restriction on the use of funds as a deterrent to effective case management.

Interagency administration and county administration failed to highlight any problems among the three responding groups which indicate the coordination and planning among county agencies and with the state agency appears to be healthy.

Levels of cooperation were highest among agencies/groups with whom the Department of Human Services contracts or refers, such as the DACs. Agencies with which the least cooperation was reported appeared to be institutions of higher learning, e.g. universities, colleges, and AVTIs.

Effectiveness of Case Management by Function

According to the directors, the most effectively accomplished functions were intake, assessment, coordination, and advocacy. Supervisors rated all functions relatively high with intake being the highest. Case managers felt support and advocacy functions the highest in effectiveness.

The area considered least effective was recordkeeping as noted by both supervisors and case managers.

A concern pointed up by questions to the case managers on client orientation was the need to advise clients of their rights and to encourage them to take an active role in the procuring and adapting of needed services.

Training Needs

The most commonly reported training needs related to negotiating with clients and service providers, assisting clients to become their own case managers, and developing the ISP.

A critical question asked only of the directors was whether the State of Minnesota should apply for Medical Assistance Funding for case management under the Consolidated

Omnibus Budget Reconciliation Act. An overwhelming majority (95%) recommended that the State should apply for these funds.

CHAPTER FIVE

SURVEY RESULTS OF SERVICE PROVIDING AGENCIES, ADVOCATES AND CONSUMERS

This chapter presents results of the survey of six important target groups concerned with the coordination of services to persons with developmental disabilities. Two groups, consumers and advocates, are highly concerned about the functioning of case management, securing services for themselves or providing assistance to others in gaining coordination services. The other target groups, service providers, school personnel, rehabilitation counselors, and public health nurses, often perform case management roles as part of their employment responsibilities within particular service agencies or more specialized service delivery systems.

Consumers

Consumers of case management services for persons with developmental disabilities were asked to respond to the survey. The survey was completed either by the client or a family member. Of the 36 responding, 94% indicated that they currently have a case manager assigned to them. The age range of the consumer or actual client was 4 years to 65 years with only 12% being school age (birth to 21 years). The mean age for the 31 respondents was 35.16 years and the standard deviation of 13.0 reflected the wide and fairly even distribution of ages.

When asked about the current residence of the consumer, 11% of the respondents indicated that they lived at home with their family. Those who lived in a group home with more than eight other people were the majority group with 71%. Those living in group homes with eight or fewer people were 14% and another 3% indicated that they had other living arrangements.

Table 60 illustrates a multi-itemed question regarding whether the consumer or other family member had ever been diagnosed as having one of several disabilities. The

Table 60

Consumers or Family Members Previously Diagnosed as Having a Developmental Disability

	Frequency of Response		Percentage of Response			
Disability	Yes	No	Yes	No	Valid Cases	Missing Cases
Mental Retardation	34	2	94	6	36	0
Cerebral Palsy	9	27	25	75	36	0
Epilepsy	7	29	19	81	36	0
Autism	0	35	0	100	35	1
Other	14	9	61	39	23	13

Note: N = 36

most common disability named was mental retardation. The next highest was an assortment of other named disabilities. No individuals reported autism in either the consumer or a family member.

The next section asked consumers to rate categories of case management services given to them according to how valuable or helpful these were (see Table 61). The continuum moved from "not helpful" (1), to "very helpful" (5), with a zero (0) coding for services which the consumer did not receive. The highest ranked case management service categories were advocacy and recordkeeping and the lowest ranked was counseling. Most other items were ranked in the "helpful" category indicating a level of satisfaction with the services rendered.

Consumers and/or family members were asked if the case manager prepared them for the staffing. Of the 36 cases, 33 responded with 58% indicating that the case manager did prepare them for the staffings and 42% indicating that they did not have prior preparation.

When asked how much time the case manager spends per month with the consumer or his/her family on the average, consumers or their family members responded in a range from no time (0) to 4.5 hours monthly. Of those who responded 54% received 18 minutes or less time from their case manager per month. The valid cases numbered 17 of the 36 possible with a mean of 1.12 and a standard deviation of 1.49.

In an effort to determine the length of time consumers had been receiving case management services, consumers or their families were asked the number of years they had been receiving services (see Table 62). With the exception of one new consumer, the range was 1 to 40 years. Over 53% of the consumer respondents were served for seven years or less.

The number of case managers who have worked with the consumer and his/her family brought the following response: 69% have had one to three case managers (of 26

Table 61

Consumer Rating of Case Management Services by Category

	Continuum															
Case Management Service Category	0 Have Not Received		1 Not Helpful		2		3		4		5 Very Helpful					
	f	%	f	%	f	%	f	%	f	%	f	%	M	S.D.	VC	MC
Assessment	4	11	2	6	4	11	8	22	7	19	11	31	3.25	1.66	36	0
Coordination	2	6	3	8	4	11	5	14	6	17	16	44	3.61	1.61	36	0
Development of IHP	3	9	5	14	3	9	5	14	5	14	14	40	3.31	1.78	35	1
Recordkeeping	3	9	1	3	4	11	5	14	5	14	17	49	3.69	1.64	35	1
Support	2	6	2	6	7	19	5	14	4	11	16	44	3.53	1.61	36	0
Linking	4	12	6	18	3	9	2	6	4	12	15	44	3.21	1.95	34	2
Monitoring/Follow-Up	3	8	3	8	3	8	5	14	7	19	15	42	3.53	1.68	36	0
Discharge	5	17	2	7	-	-	6	21	6	21	10	34	3.24	1.86	29	7
Advocacy	2	6	2	6	3	9	5	15	6	18	16	47	3.74	1.56	34	2
Counseling	5	14	5	14	3	18	5	14	5	14	13	36	3.08	1.89	36	0

Note: N = 36

139

140

Table 62

Length of Time Consumers Have Received Case Management Services

Number of Years	Frequency of Response	Percentage of Response	M	S.D.	V.C.	M.C.
0 - 10	15	53.5	13.07	11.4	28	8
11 - 20	5	17.9				
21 - 30	7	25.0				
31 - 40	1	3.6				

Note: N = 36

valid cases), while 35% have had four to fifteen case managers. One individual had not yet been assigned a case manager (4%). The mean was 3.27 case managers, somewhat inflated due to the fact that some individuals were served over a 30 to 40-year period. The bulk of responses fell into the one to two case manager category. The standard deviation was 3.28.

A follow-up question sought to determine whether the change in case manager affected the consumer, his/her family and the services received. Table 63 illustrates the results. For 77% of the consumers, the change either did not affect services or it improved them. The remaining 23% indicated that change caused delay or disruption in services. (Written-in responses for "other" included negative changes and thus are included in the 23%).

When asked if family members or the consumer had received any training in working with the case management system, 20% of the 35 respondents said "yes," while 80% indicated that they had no such training. A follow-up question for those who responded that they did have training asked where the training was received. Results indicated that 43% took formal college courses, 33% gained information from inservice or workshops, 20% gained information from an advocate, and 57% from the case manager. Valid cases for this branch item ranged from five to seven consumers. Respondents could choose more than one response category.

Asked if the consumer and/or his/her family would like to receive training in working with the case management system, 24% indicated "yes," while the majority (76%) said, "no." A follow-up question to those who responded affirmatively asked if they would like to attend a workshop on how to work with the case management system. All of the six respondents indicated that they would like to do so. A smaller number (3) indicated that they would like an advocate to assist them in working with the case management system.

Table 63

Effect of Change in Case Manager on Services Received by Consumers and Their Families

Result of Change	Frequency of Response	Percentage of Response	M	S.D.
Change in case managers has not affected service	11	42.4	2.15	1.12
Change in case managers caused delay/disruption of services and planning	3	11.5		
Change in case manager improved services	9	34.6		
Other	3	11.5		

Note: N = 36
Valid Cases = 26
Missing Cases = 10

The most common responses to the question of what the consumer sees as gaps in service are the following: (a) case managers not getting to know their clients and their needs, (b) heavy caseloads, and (c) lack of knowledge of available resources and application of the regulations. Less than half (14) of the consumers responded to this open-ended question.

The next section of the survey addressed whether the consumer had to wait for particular services or a change in services. Of 27 respondents, 30% indicated that they waited for an individual service plan to be developed, while the majority (70%) had no such complaint. When asked if they had to wait for a service to be provided, a similar response was gained: 33% indicated that they did have to wait for the service (30 valid cases), while the majority (67%) had no such wait. When asked if they waited for a needed change in service, 39% indicated that they waited, while 61% had no significant waiting period of 28 valid cases. The valid cases of those who were required to wait was two to four respondents.

Consumers and their families were asked if they believed they could be their own case manager. Of the 33 respondents, 39% indicated that they felt they could, while 61% did not feel it was their role. When asked if they currently acted as their own case manager, 15% of the 34 respondents said "yes," while the majority (85%) said that they do not serve in this capacity. In a similar vein, the survey asked if the consumer or a family member acts as an advocate for services. Of the 33 respondents, 52% said "yes," and 48% said "no."

Consumers and their families were asked if they had ever been requested to evaluate case management services. The majority (94%) of the 33 respondents indicated that they had never been asked to do so.

The next section asked if helpful case management services had been received by the consumer during specific age periods. Table 64 illustrates the results. The greatest

Table 64

Case Management Services Received by Consumers Per Time Span

Time Span	Frequency of Response			Percentage of Response			Valid Cases	Missing Cases
	N.A.	Yes	No	N.A.	Yes	No		
Birth - 7 years	10	13	8	32	42	26	31	5
7 - 21 years	8	21	3	25	66	9	32	4
21 - 25 years	7	22	1	23.3	73.3	3.3	30	6
35 - 65 years	9	12	2	39	52	9	23	13
65 and older	10	2	-	83	17	-	12	24
Entering and exiting school setting	6	13	1	30	65	5	20	16
Entering and exiting residential setting	3	18	1	13.6	81.8	4.6	22	14

Note: N.A. = Not Applicable
N = 36

percentage of respondents indicated that case management services were received during the 21 to 25 year age level, with the school age group (7-21 years) following next. Significant percentages were also noted when persons with developmental disabilities entered or exited school or residential programs.

The last section of the survey addressed rating the case management services which had been received by the consumer. Table 65 illustrates the results. The majority (75%) indicated that they were satisfied with services rendered, ranking those from "good" to "excellent."

Summary

Generalizations on this section of the study are based on a small number of responding consumers (36) and many may not apply to the total population of persons with developmental disabilities.

Some of the major consumer concerns were: (a) case managers not knowing client needs, (b) heavy caseloads, and (c) lack of knowledge regarding available resources. There was also an interest on the part of consumers and their families for additional training in working with the case management system.

On a scale from one (1) to five (5), consumers felt that case management functions were adequately performed (3). Approximately half of the respondents reported an average of 18 minutes or less time per month received in case management services. Over 94% of the consumer respondents have never been asked to evaluate case management services.

Table 65

Consumer Rating of Case Management Services Received

Rating	Code	Frequency of Response	Percentage of Response	*M*	S.D.	VC	MC
Poor	1	3	9	3.39	1.22	33	3
Fair	2	5	15				
Good	3	7	21				
Very Good	4	12	36				
Excellent	5	6	18				

Note: N = 36

Service Providers

Providers of residential, day program, support, and other services for persons with developmental disabilities were asked to complete the case management survey and 131 individuals responded (see Table 66). In order to determine the type of service provided by respondents, a list of four options was presented and service providers were asked to check those which applied. Some programs offered more than one type of service; for example, a day program might also provide support service to the client and his/her family. Thus the percentage total exceeds 100%. Results indicated that over 50% of the respondents worked in day programs and 47% served clients in residential programs.

Service providers were asked to indicate the number of clients with developmental disabilities they served during the 1986 calendar year. Table 67 illustrates the results. The mean was over 63 clients per year with an exceptionally wide range of 1 to 950 clients. The heaviest cluster of responses fell between 5 and 57 clients (67%).

Training

When asked what type of training the service providers had taken by topical area, the majority had taken both formal coursework (88%) and inservice training (93%) in the area of developmental disabilities (see Table 68). The area where the least training took place was in brokering and negotiating services. Since respondents were direct service providers, the need for such training may not be felt to be critical for their daily tasks.

Planning and Service Delivery

Service providers were asked what the average time lapse is between the writing of the Individual Service Plan (ISP) and the initiation of services (see Table 69). The range was no lapse, i.e., immediate initiation of service, in 42% of the service providers' experiences to 210 days, an exceptionally long wait for service. The majority (62%) indicated that services were provided within a ten day period. However, 22% of the respondents indicated that a 21 to 50-day lapse in time was also common.

Table 66

Type of Service Provided by Service Provider Respondents

Type of Service	Frequency	Percentage	Valid Cases
Residential	62	47.3	131
Day Program	69	52.7	
Support	15	11.5	

Note: N = 131
Subjects could check more than one type of service.

Table 67

Clients with Developmental Disabilities Served by Service Providers During 1986

Number of Clients	Frequency	Percentage	Mean	Standard Deviation
0 - 20	43	33.6	63.37	113.7
21 - 40	32	25.0		
41 - 60	10	7.8		
61 - 80	17	13.3		
81 - 100	7	5.5		
101 - 200	16	12.6		
201 - 950	3	2.2		

Note: N = 131
Valid Cases = 128

Table 68

Type of Training Taken by Service Providers by Topical Area

	Formal Coursework				Inservice/Workshops			
Topical Area	f	%	f	%	f	%	f	%
	Yes		No		Yes		No	
Case Management	69	61	45	39	85	75	29	25
Developmental Disabilities	100	88	14	12	106	93	8	7
Brokering/Negotiating Services	24	21	90	79	39	34	75	66
Development of Individual Plans/ Programs	62	54	52	46	98	86	16	14

Note: N = 114
Valid Cases = 114

Table 69

Average Time Lapse in Days Between Writing of ISP and Initiation of Services

Time Lapse (Days)	Frequency	Percentage	Mean	Standard Deviation
0	49	42	14.4	25.94
1 - 5	10	8		
6 - 10	14	12		
11 - 15	9	8		
16 - 20	2	2		
21 - 50	28	22		
51 - 210	5	4		

Note: N = 131
Valid Cases = 117

The average time lapse between the writing of the Individual Habilitation Plan (IHP) and the initiation of service was asked (see Table 70). The range, not as wide as responses to the previous question, was no time lapse (37%) to 90 days (2%). The mean was approximately 12 days.

When asked if the service providers were involved in the writing of the IHP, 70% of the 124 respondents indicated "yes," while the remaining 30% said that they were not involved. The follow-up question for those responding "no," asked if they would like to be involved. Of the 39 respondents, 46% indicated that they would like to be involved and 54% indicated that they preferred not to be.

Numbers of Case Manager and County Contacts

The number of case managers with whom the service providers dealt in the 1986 calendar year yielded a range of 0 to 46 case managers (see Table 71). Of the 109 respondents, 74% had contact with 1 to 15 case managers, while another 6% dealt with as many as 36 to 46 case managers annually.

A similar question asked the number of counties with which service providers typically dealt in 1986 (see Table 72). The range was from one to 24 counties. The majority dealt with 1 to 10 counties in Minnesota. The average number of counties was six.

Follow-up Procedures

Service providers were presented with four choices of procedures they might follow if a client's needs were not being met (see Table 73). Respondents could choose more than one option. Clearly, the procedure of choice was contacting the case manager immediately (100% of the respondents), followed by calling for an interdisciplinary meeting and notifying the client or guardian. The least popular option (30%) was waiting for an interdisciplinary meeting to be called.

Table 70

Average Time Lapse in Days Between the Writing of the IHP and Initiation of Services

Time Lapse (Days)	Frequency	Percentage	Mean	Standard Deviation
0	44	37	11.94	15.1
1 - 5	8	7		
6 - 10	20	17		
11 - 15	17	14		
16 - 20	3	2		
21 - 50	25	21		
51 - 90	2	2		

Note: N = 131
Valid Cases = 119

Table 71

Number of Case Managers with Whom Service Providers Worked During 1986

Number of Case Managers	Frequency	Percentage	Mean	Standard Deviation
0 - 5	41	38	11.56	9.98
6 - 10	24	22		
11 - 15	16	14		
16 - 20	11	10		
21 - 25	5	5		
26 - 30	6	5		
31 - 35	1	1		
36 - 40	4	5		
41 - 46	1	1		

Note: N = 131
Valid Cases = 109

Table 72

Number of Counties With Which Service Providers Worked In 1986

Number of Counties	Frequency	Percentage	Mean	Standard Deviation
0 - 5	64	55	6.2	4.9
6 - 10	35	30		
11 - 15	13	11		
16 - 20	1	3		
21 - 24	4	1		

Note: N = 131
Valid Cases = 117

Table 73

Procedures Employed by Service Providers When Client Needs Are Unmet

Procedures (more than one can be checked)	Frequency	Percentage
Notify case manager immediately	114	100
Call for interdisciplinary team meeting	88	77
Wait for interdisciplinary team meeting	34	30
Notify client/guardian	86	75

Note: N = 131
Valid Cases = 114

Paperwork and Meetings

When asked how much time is spent monthly on paperwork for each client with developmental disabilities, the range was 12 minutes to 15 hours (see Table 74). The average amount of time dedicated to paperwork was slightly more than three hours per client.

A similar question addressed the amount of time per client spent in meetings monthly. The range was none to ten hours each month (see Table 75). Of the 101 respondents 63% spend an hour or less in meetings per client. The mean was slightly over one and one-half hours per month.

Evaluation

When asked if evaluation of case management services is ever performed, 116 responded. Of the group, 66% indicated that such evaluation did not take place, while 33% indicated that it did.

A follow-up question addressed the frequency with which case management services were evaluated. Of the 37 respondents, 43% indicated that this was done annually, 22% indicated that it was accomplished semi-annually, 16% said quarterly, 8% said monthly, and 11% indicated other periods of time for evaluation.

A listing of case management functions identified in Rule 185 for case managers was presented to the service providers with a five-point rating scale. Table 76 describes the results. Respondents were asked to indicate the effectiveness of county case managers in carrying out these functions. The highest rated function was intake with a 3.3 mean, indicating a moderately effective rating. The lowest ratings were accrued in the areas of recordkeeping and developing the IHP with a mean of 2.3 or "slightly effective." Generally, scores were low with service providers indicating some level of disenchantment with the system.

Table 74

Average Time Spent Monthly On Paperwork Per Client

Time (in hours)	Frequency	Percentage	Mean	Standard Deviation
0 - 1.0	31	32	3.21	2.98
2.0	22	22		
2.1 - 3.0	10	10		
3.1 - 4.0	10	10		
4.1 - 5.0	7	7		
5.1 - 10.0	17	17		
10.1- 15.0	2	2		

Note: N = 131
Valid Cases = 99

Table 75

Average Time In Hours Spent Monthly In Meetings Regarding Each Client

Average Time (in hours)	Frequency	Percentage	Mean	Standard Deviation
0 - 1.0	64	63	1.59	1.74
1.1 - 2.0	17	17		
2.1 - 3.0	11	11		
3.1 - 4.0	2	2		
4.1 - 5.0	3	3		
5.1 - 6.0	1	1		
6.1 - 10.0	3	3		

Note: N = 131
Valid Cases = 101

Table 76

Ratings Of Effectiveness Of Case Management Services By Function

Function	0 Unknown f	0 Unknown %	1 Not Effective f	1 Not Effective %	2 Slightly Effective f	2 Slightly Effective %	3 Moderately Effective f	3 Moderately Effective %	4 Effective f	4 Effective %	5 Very Effective f	5 Very Effective %	M	Standard Deviation	Valid Cases
Intake	7	5	4	3	11	9	41	32	55	43	10	8	3.3	1.2	128
Assessment	3	2	14	11	37	29	43	33	27	21	5	4	2.7	1.1	129
Planning	4	3	24	19	36	28	41	32	18	14	5	4	2.5	1.2	128
Coordination	1	1	20	16	39	30	36	28	25	20	7	5	2.7	1.1	128
Develop IHP	5	4	32	25	38	30	30	24	19	15	3	2	2.3	1.2	127
Recordkeeping	20	16	11	9	37	29	32	25	22	17	6	5	2.3	1.4	128
Support	12	9	19	15	25	20	38	30	20	16	13	10	2.6	1.4	127
Linking and Brokering	4	3	23	18	32	25	35	28	27	21	6	5	2.6	1.2	127
Monitoring/ Following Progress	1	1	20	16	28	22	52	40	20	16	7	5	2.7	1.1	128
Discharge	20	16	18	14	20	16	34	27	29	23	5	4	2.4	1.5	126
Overall Effectiveness	0	0	15	12	34	27	46	37	23	18	7	6	2.8	1.1	125

Note: N = 131

When asked what other functions case management could provide to support the provision of services, a wide range of responses was gained. A significant number indicated that services should be more client-centered with focus on advocacy, while others felt that the case managers should not be given other duties since their caseloads were already too heavy.

The question of whether sufficient information is provided by the case managers to arrange appropriate services for the client showed that in the majority of cases (72%) such information is usually provided. The remaining 123 respondents indicated that seldom (28%) was the information provided and in 1% of the cases, never provided.

Summary

In summary, service providers were generally unhappy with the accomplishment of case management functions, but usually gained appropriate placement information from them regarding the client with developmental disabilities.

In regard to training, the majority of service providers had taken coursework and inservice in the area of developmental disabilities. The average number of counties with whom service providers dealt was six and the average number of case managers was 11. Typically, service providers contacted the case manager when service needs of the client were not being met. The majority of service providers indicated that they were not invited to evaluate county case management services.

School Personnel

School personnel who serve as case managers were asked to complete the survey and 143 responded statewide.

Education and Background

Regarding educational background, 55% of the 126 valid cases indicated that they held a bachelor's degree; 44% held a master's degree; one percent held a specialist certificate; and another one percent held a degree in a related field.

Of the 143 respondents to the second question regarding occupational title, 65% reported being teachers. Table 77 illustrates the results. A follow-up question asked how long each of the 94 respondents has held his/her current position. The range was one to 34 years for teachers with a mean of over 10 years (see Table 78). School social workers (26 respondents) had a similar range of years served: one to 33 years with a mean of almost 12 years for the 26 reporting social workers (see Table 79). Educational case managers or service coordinators (15 respondents) had served in their positions from one to 23 years with a mean of over eight and one-half years (see Table 80). For due process coordinators or service coordinators or specialists, the three respondents had served from one to 13 years with a mean of 5.3 years in that position. The four respondents who fell into "other" categories served an average of three years in their respective positions as lead teacher, coordinator, or director.

The next questions addressed the length of time the individual had served as a special education case manager (see Table 81) and the settings in which they worked. Of the 121 respondents to this question, the most common responses fell between one and ten years (73%) with nearly 12 years as a mean.

In regard to the setting in which the special education case managers worked, respondents were free to check more than one response reflecting their past work history; thus, percentage totals exceed 100% (see Table 82). Interestingly, 97% of the 127

Table 77

Occupational Title by Frequency and Percentage

Occupational Title	f	%
Teacher	94	65
School social worker	26	18
School psychologist	0	
Educational case manager/ services coordinator	15	11
Due process coordinator/ specialist	3	2
Other	5	4

Note: N = 143

Table 78

Length of Time Served as Teacher by Frequency and Percentage

Years	Frequency	Percentage	*M*	VC	S.D.
0 - 5	26	28	10.7	94	7.8
6 - 10	28	30			
11 - 15	19	20			
16 - 20	11	12			
20 - 34	10	10			

Note. N = 127

Table 79

Length of Time Served as School Social Worker by Frequency and Percentage

Years	Frequency	Percentage	M	VC	S.D.
0 - 5	3	11	11.9	26	6.7
6 - 10	10	38			
11 - 15	7	27			
16 - 20	5	19			
21 - 33	1	5			

Note. N = 127

Table 80

Length of Time as Educational Case Manager/Services Coordinator by Frequency and Percentage

Years	Frequency	Percentage	M	SD	VC
1 - 5	6	40	8.6	6.4	15
6 - 10	4	26			
11 - 15	2	13			
16 - 20	2	13			
21 - 23	1	8			

Note. N = 127

Table 81

Length of Time Served as Special Education Case Manager

Years	Frequency	Percentage	M	SD	VC
0 - 5	34	28	11.9	6.7	121
6 - 10	54	45			
11 - 15	19	16			
16 - 20	12	9			
21 - 25	2	2			

Note. N = 127

Table 82

Settings in Which Special Education Case Managers Worked

Setting	Frequency	Percentage
Level 2 consultation	72	59
Resource consultation	88	73
Self-contained classroom	71	59
Residential setting	119	97
Regular education setting	48	40
Other	9	7

Note. N = 127
Valid cases = 121

respondents indicated that they had previous experience in residential settings. The next highest response category was the resource classroom with 73% having had experience in that setting.

Training

Special education case managers were asked if they had taken coursework or workshops to prepare them for their role as a case manager. Table 83 illustrates that no coursework or workshops were taken on the subject of case management prior to 1969, that only 12% of the 68 respondents indicated training between 1970 and 1980, and 34% had taken training after 1981. The majority of respondents (80%) took either one or no courses or training in the subject of case management. Such results would indicate a great need for training in the area.

Another question addressed the amount of training school personnel had received to prepare the individual to work with students having severe handicaps. Table 84 shows that 68% of the 59 respondents had either no training or one course. Prior to 1969 through 1980, the majority of respondents indicated that they had no training. More recently (1981 to 1987), 38% of 57 respondents reported taking from one to five courses in the area.

Regarding the question on training for transition planning or movement from special education to adult services, 64% of the 127 respondents had no training experiences in the area (see Table 85). Most of the training occurred after 1981 with 31% reporting taking one to five courses on transition planning.

Special education personnel were asked what areas of licensure they currently held. Since most were certified in more than one area, total percentages exceed 100% as shown on Table 86. The majority (77.7%) held licensure in educable mentally handicapped (EMH). The next most frequent response was licensure as a regular elementary education teacher. Since many special education teachers also hold either an elementary or

Table 83

Number of Training Experiences Taken in Special Education Case Management and Year Attended for School Personnel

Courses Taken < 1969	f	%	VC	MC
0	68	100	68	59
Courses Taken < 1970 - 1970				
0	60	88	68	59
1	5	8		
4	2	3		
5	1	1		
Courses Taken > 1981				
0	44	66	68	59
1	11	16		
2	7	10		
3	2	3		
6	3	4		
45	1	1		

Number of Courses	f	%	M	SD	VC	MC
0	40	58	1.67	5.69	70	57
1	15	22				
2	8	11				
3	2	3				
8	1	1				
10	2	3				
11	1	1				
45	1	1				

Note. N = 127

Table 84

Number of Training Experiences in the Education of Students with Severe Handicaps

Courses Taken < 1969	f	%	VC	MC	Number of Courses	f	%	M	SD	VC	MC
0	52	90	58	69	0	26	44	1.1	1.37	59	68
1	3	5			1	14	24				
2	3	5			2	12	20				
					3	3	5				
					4	2	3				
					5	1	2				
Courses Taken < 1970-81					6	1	2				
0	47	82	57	70							
1	5	9									
2	4	7									
4	1	2									
Courses Taken >1981											
0	36	62	57	70							
1	10	18									
2	7	12									
3	2	4									
4	1	2									
5	1	2									

Note. N = 127

Table 85

Training Experiences Taken in Transition Planning and Year Attended for School Personnel

Courses Taken < 1969	f	%	VC	MC	Number of Courses	f	%	M	SD	VC	MC
0	97	100	97	30	0	63	64	0.5	0.85	98	29
					1	26	27				
					2	7	7				
Courses Taken < 1970-80					4	1	1				
					5	1	1				
0	93	96	97	30							
1	2	2									
2	2	2									
Courses Taken > 1981											
0	67	69	97	30							
1	23	24									
2	5	5									
4	1	1									
5	1	1									

Note. N = 127

Table 86

Areas of Current Professional Licensure/Certification Held by School Personnel

Area	Frequency	Percentage
Educable Mentally Handicapped	94	77.7
Regular Education Teacher (elementary)	66	54.5
Trainable Mentally Handicapped	54	44.6
Learning Disabled	39	32.2
School Social Work	27	22.3
Regular Education Teacher (secondary)	19	15.7
Emotionally/Behaviorally Disordered	14	11.5
Supervisory	8	6.6
Vocational/Work Experience	7	5.8
Other: P.E., Music, Reading	7	5.8
Early Childhood/Kindergarten	6	4.9
School Administrator	3	2.5
Physically Handicapped	3	2.5
Visually Impaired	1	.8

Note. N = 121
Valid cases = 121

secondary license in addition to their special education license, this finding is not unusual. No representation was shown in school psychology, speech pathology, or education of the hearing impaired. The bulk of licenses were issued for personnel in teaching educable and trainable mentally handicapped.

Options were presented regarding how case management services are typically handled in the school setting (see Table 87). Of the 127 respondents, 94% indicated that a staff person who is also providing direct services to the student is assigned the case manager role. Only a small percentage (3%) indicated that a staff member who was not a direct service provider was assigned to the case manager role. This would indicate that a small percentage of time could be dedicated to case management functions by the direct service providers in the schools.

Planning and Service Delivery

The next question addressed whether the special education case manager assisted with the management of specific services. Of the 118 respondents, 92% indicated that they manage school-based services only. Of 101 respondents, 58% planned for post-secondary services only. The remaining 30 respondents (53%) had a variety of responsibilities which included family services, work with community agencies, vocational, transition, and support services.

Special education case managers were asked whether or not certain case management responsibilities were carried out by them (see Table 88). The majority (84-99%) of the respondents indicated that all of these were their responsibilities, such as ensuring that the student and family's views were heard and integrated into the plan.

For the 1986 calendar year, school personnel were asked what percentage of individual education plan (IEP) meetings were attended by a parent or guardian. Table 89 shows the results with a range of 2% to 100%. The mean of over 85% indicated that most of the time parents or guardians were present at the meetings.

Table 87

Methods of Handling Case Management Service by Frequency and Percentage

Method	Frequency	Percentage
A staff person who is also providing direct services to the student is assigned the case manager role.	119	94
A staff person who is not providing direct service to the student is assigned the case manager role.	4	3
Educational case management or Due Process specialists provide case management services.	1	1
Other	3	2

Note. N = 127
Valid cases = 127

Table 88

Responsibilities of Special Education Case Managers

Responsibility Statements	Currently Special Education Case Manager Responsibility				
	Yes		No		
	frequency	percentage	frequency	percentage	NC
Ensure that the service plan review meeting is held	122	98	2	2	124
Ensure that the plan update is jointly developed	121	98	2	2	123
Ensure that student/family's views are heard and integrated into plan	124	99	1	1	125
Advocate for client when he/she disagrees with team	99	84	19	16	118
Write the plan document and distribute it to client and team members	117	94	7	6	124

Note. N = 127

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Table 89

Percentage of Individual Education Plan Meetings Attended by Parent or Guardian During 1986

Percentage of IEP meetings attended by parents/guardians	Frequency of Response	Percentage of Response	M	S.D.	VC
0 - 10	2	2	85.2	21.3	121
11 - 20	1	1			
21 - 30	4	3			
31 - 40	0	0			
41 - 50	4	3			
51 - 60	6	5			
61 - 70	2	2			
71 - 80	17	14			
81 - 90	24	20			
91 - 100	61	50			

Note. N = 127

The next section dealt with monitoring the degree to which the IEP objectives are met (see Table 90). Of the 127 respondents, 96% indicated that they did engage in monitoring for this purpose. Special education case managers were asked to respond "yes" or "no" as to whether they used specific systems of monitoring. Holding annual review meetings and revising the IEP as necessary were procedures employed by 100% of the respondents. The lowest "yes" response (69%) still represented a majority of special education case managers making periodic visits to the student during the school day.

The next question dealt with how the special education case managers dealt with a situation where a student with disabilities had a specific need, but the services were unavailable to him/her (see Table 91). A set of options was presented and respondents could answer with a "yes" or "no." The most frequently selected option with 98% of 108 respondents was to recommend appropriate alternatives. The least popular alternatives were to wait until an annual review meeting (11%) or to postpone writing the need into the IEP (28%).

Vocational Education Offered

Respondents were asked to indicate the percentage of students in given age ranges who received services from vocational education through a formal vocational education program. Table 92 describes the results. The majority (67%) of special education case managers indicated that no formal vocational program served the age group of six through 15 years. For the older age group of 16 to 21 years, the mean percentage of time in which students were served by formal vocational education programs was approximately 50% as reported by 71 case managers. Traditionally, vocational programs have served the age group 14 years and above and thus, the results appear to reflect this emphasis on vocational programming at a later age.

Table 90

Systems of Monitoring IEP Objectives Employed by Special Education Personnel

Systems of Monitoring	Frequency of Response	Percentage of Response	Frequency of Response	Percentage of Response	VC
	Yes		No		
Periodic visits to student during school day	58	69	26	31	84
Review of teacher's records and reports	85	91	8	9	93
Holding periodic student reviews	70	80	17	20	87
Holding periodic family interviews	68	80	17	20	85
Holding annual review meetings	109	100	0	0	109
Revising IEP as needed	112	100	0	0	112

Note. N = 127

Table 91

Options Selected by Special Education Managers When Needed Services are Unavailable

Case Manager Options	Frequency of Response	Percentage of Response	Frequency of Response	Percentage of Response	VC
	Yes		No		
Write the need into IEP	70	74	25	26	95
Postpone writing need into IEP until service is available	21	28	55	72	76
Recommend appropriate alternatives	106	98	2	2	108
Set date to review alternative program/service needs	75	82	16	18	91
Assign someone to develop program/services	69	74	24	26	93
Notify proper authorities of gap in program/services	97	92	9	8	106
Wait until annual review meeting	8	11	68	89	76
Schedule a review meeting	73	85	13	15	86

Note. N = 127

Table 92

Percentage of Student by Age Range Receiving Formal Vocational Education Programs

Percentage of Students	Frequency of Response	Percentage of Response	M	S.D.	Valid Cases
	Age: 6 - 15 years				
0	56	67	16.79	31.76	84
5 - 25	11	13			
26 - 50	6	7			
51 - 75	2	2			
76 - 100	9	11			
	Age: 16 - 21 years				
0	19	27	50.39	42.4	71
1 - 25	11	15			
26 - 50	4	6			
51 - 75	11	15			
76 - 100	26	37			

Note. N = 127

Case Management Functions

The next section addressed case management functions and the estimated monthly percentage of time the special education case manager typically devotes to each function. Table 93 describes the results. All of the functions were performed by the majority of respondents with a range in percentages from 69% (interagency activities) to 96% (monitoring and follow-up). Estimated time ranged from 0 to 100% per function, though the directions requested respondents to figure on the basis of their total job. The highest percentage of time appeared to be in recordkeeping with a mean of 16.7% and the least time-consuming activity appeared to be discharge or termination of a student with a mean of 4.4%.

Effectiveness

Special education case managers were asked to rate the effectiveness of the case management delivery system by function in their school settings (see Table 94). The function/activity considered most effective by respondents was developing the IEP with a mean of 3.97. Activities with other agencies ranked lowest with only a slightly effective rating (2.46). This finding may be due to the fact that the majority of school personnel assigned to case management activities also provide direct service to students in the classroom, thereby eliminating time for community agency contacts.

When asked what special concerns school personnel have experienced with case management responsibilities, respondents answered with a variety of problems. The most common complaint (44 responses) was the lack of time and scheduling problems in completing the work, with the second most frequently named problem (17 responses) being the amount of paperwork required.

Training Needs

The last survey question listed topics for inservice which relate to case management responsibilities and asked respondents to identify areas in which they needed additional

Table 93

Case Management Functions Performed by Special Education Case Managers and Estimated Monthly Percentages of Time Spent Per Function

Function Performed	Frequency Yes	Frequency No	Percentage Yes	Percentage No	VC	Estimated Percentage of Time Per Function Range	M	S.D.	Valid Cases
Screening	95	2	77	23	12	0 - 100	6.09	11.4	105
Assessment	113	10	91	9	123	0 - 100	10.5	13.8	123
Coordination	112	9	92	8	121	0 - 100	16.6	22.0	102
Develop IEP	119	6	95	5	125	0 - 90	11.9	13.3	104
Recordkeeping	117	8	94	6	125	0 - 80	16.7	17.9	103
Support	91	26	78	22	117	0 - 100	7.8	16.7	86
Inter-agency activities	81	37	69	31	118	0 - 100	4.8	13.8	97
Monitoring/follow up	114	5	96	4	119	0 - 100	12.8	21.7	92
Discharge	104	14	88	12	118	0 - 100	4.4	13.8	86
Advocacy	104	13	89	11	117	0 - 100	12.2	22.5	85
Counseling	93	23	80	20	116	0 - 100	7.9	14.6	91

Note. N = 127

Table 94

Effectiveness of Case Management Service Delivery by Function as Rated by Special Education Case Managers

	0		1 Not Effective		2 Slightly Effective		3 Moderately Effective		4 Effective		5 Very Effective				
	f	%	f	%	f	%	f	%	f	%	f	%	M	Standard Deviation	Valid Cases
Screening	28	23	1	1	6	5	16	13	50	41	22	18	3.02	1.81	123
Assessment	10	8	-	-	4	3	20	16	61	50	28	23	3.68	1.32	123
Coordination	9	7	-	-	8	7	25	21	53	44	26	21	3.58	1.31	121
Develop IEP	5	4	1	1	1	1	16	13	64	52	27	30	3.97	1.09	124
Recordkeeping	7	6	-	-	9	7	37	30	44	35	27	22	3.55	1.23	124
Support	23	21	2	2	11	10	20	19	37	34	15	14	2.84	1.73	108
Interagency Activities	35	31	1	1	10	9	23	20	52	48	12	11	2.46	1.83	113
Monitoring/ Follow-up	6	6	-	-	8	7	25	23	52	48	18	17	3.57	1.81	109
Discharge	14	13	-	-	3	3	20	19	49	46	20	19	3.42	1.51	106
Advocacy	13	13	-	-	5	5	20	20	41	40	23	23	3.42	1.53	102
Counseling	23	22	1	1	12	11	22	21	28	27	19	18	2.84	1.77	105

Note. N = 127

training. The most frequently cited areas were: (a) information on transition (62 responses), (b) methods for creative problem solving in the team process (58), (c) ways to assist students/families in self-advocacy activities (57), (d) identifying the student's personal goals, preferences, strengths, and needs (49), (e) how to monitor individual program plans (48), and (f) how to plan and implement effective programs.

Summary

School personnel serving as case managers appeared to be qualified educationally for their positions, but may need greater inservice training in transition issues and work with students having severe handicaps.

Of the school personnel respondents, 97% serving as case managers also provided direct service to the students, i.e., classroom teaching, and 92% provided management of school-based services only. This finding may be due to lack of teacher time for coordination with other agencies.

Vocational education was not typically provided to children between 6 and 15 years of age as reported by the majority of respondents, but was provided to approximately 50% of students in the 16-21 year age group.

The greatest amount of time in case management appeared to be recordkeeping, and the most common problems were lack of time, scheduling problems, and the heavy amount of required paperwork.

Rehabilitation Counselors

Rehabilitation counselors were surveyed and 67 responded. However, after the first few items, responses dwindled to about one-third of the total number of counselors. Thus, some of the data reported will be representative of a smaller population. In such cases, a short commentary in the text will replace information written in tabular form.

Education and Background

Table 95, Academic Degree and Major by Number and Percentage of Responses, illustrates both the highest level of educational attainment and major field of rehabilitation counselors. The majority had attained a master's degree and were majors in psychology.

A multi-itemed question addressed whether counselors had training in the past year on basic case management functions. Of the 62 responding, 95% had no training on Rule 185 County Case Management Services. In the area of developmental disabilities, 65 counselors responded, 48% of whom indicated that they had training in the area and 52%, indicating they had no training. Brokering and negotiations was an area where 97% of the 59 respondents indicated they had no training. Individual habilitation planning (IHP) had similar results with 97% of the 60 respondents indicating that they had no training in this area. Training in the area of individualized service planning (ISP) showed some slight improvement with 62 responding. Nineteen percent indicated that they had training, while 81% said that they had no such training during the past year. The last training item addressed interagency coordination of services. Of the 64 respondents, 59% had previous training, while 41% did not.

The length of time in years which the counselor had served in the Division of Rehabilitation Services is illustrated on Table 96, the mean showing considerable experience, namely over 10 years.

Caseloads

Table 97, Approximate Case Load by Number and Frequency of Response, shows that the majority (67%) of counselors have client caseloads ranging between 126 and 200 clients. The range was from 1 to 400 with a high variance (62.5) due partially to a few very high responses. The mean caseload was nearly 159 clients.

Table 95

Academic Degree and Major by Number and Percentage

Degree	Number of Responses	Percentage of Responses
Baccalaureate	12	18
Masters	54	81
Doctorate	1	1
Major		
Social Work	2	5
Psychology	33	39
Sociology	1	3
Education/Teaching	1	3

Note: Valid Cases Degree = 67
Missing Cases Degree = 0
Valid Cases Major = 37
Missing Cases Major = 30

Table 96

Years as a Counselor in the Division of Rehabilitative Services by Number and Frequency of Responses

Years as Counselor	Number of Responses	Percentage of Responses	_M_	S.D.
1 - 4	6	9	10.7	5.2
5 - 8	17	26		
9 - 12	19	29		
13 - 16	12	18		
17 - 20	11	17		
21	1	2		

Note: N = 67
Valid Cases = 66
Missing Cases = 1

Table 97

Approximate Case Load by Frequency and Percentage of Responses

Approximate Caseload	Frequency of Responses	Percentage of Responses	Mean	S.D.
1 - 25	1	1	158.93	62.56
26 - 50	0	0		
51 - 75	2	3		
76 - 100	4	6		
101 - 125	9	14		
126 - 150	19	29		
151 - 175	16	24		
176 - 200	9	14		
201 - 225	0	0		
226 - 250	2	3		
251 - 275	0	0		
276 - 300	2	3		
301 - 400	2	3		

Note: N = 67
Valid Cases = 66

The number of persons with developmental disabilities served by the counselor each year was requested. Table 98, Approximate Number of Persons with Developmental Disabilities Served Per Year by Number and Frequency of Responses, describes the results. Over 50% of the 66 respondents worked with 1 to 40 individuals with developmental disabilities. The standard deviation of 26.08 indicated a high degree of variance.

Table 99, Percentage of Case Load Time Spent with People with Developmental Disabilities by Number and Frequency of Response, showed that 73% of the 62 reporting counselors spent between 1 to 30% of their time serving these clients. The variance, again, was rather high, the standard deviation being 20.89.

When counselors were asked if they knew what the "Department of Human Services, Rule 185 Case Management Services" were, 64 responded. Of this group 33% indicated that they knew, while 67% were unaware of the rule.

Cooperative Efforts with County Case Managers

Slightly over half of the counselors responded to the item which asked how many cases they worked on cooperatively with a Rule 185 county case manager (see Table 100). It is interesting to note that although some of the same counselors were not aware of Rule 185, they had worked cooperatively on cases with the county case manager.

The next item was a branch of the two questions reported immediately above and thus, the valid cases (VC) are fewer in number. Table 101 describes the number of different Rule 185 case managers with whom the rehabilitation counselors worked over the past year.

The next item addressed how case coordination services in the counselors' own Division of Rehabilitation Services (DRS) differed from Rule 185 case management services provided by county human services personnel. Although the number of valid cases was small, the differences identified by the 18 who responded indicated a greater

Table 98

Approximate Number of Persons with Developmental Disabilities Served Per Year by Frequency and Percentage of Responses

Approximate Number	Frequency of Responses	Percentage of Responses	Mean	S.D.
0 - 10	8	12	36.74	26.08
11 - 20	15	22		
21 - 30	17	25		
31 - 40	3	5		
41 - 50	12	18		
51 - 60	2	3		
61 - 70	2	3		
71 - 80	2	3		
81 - 90	2	3		
91 - 100	1	2		
101 - 110	1	2		
111 - 120	1	2		

Note: N = 67
Valid Cases = 66

Table 99

Percentage of Case Load Time Spent with People with Developmental Disabilities by Frequency and Percentage of Response

Percentage of Caseload Time	Frequency of Responses	Percentage of Responses	Mean	S.D.
0	1	2	26.48	20.89
1 - 10	17	27		
11 - 20	12	19		
21 - 30	17	27		
31 - 40	2	3		
41 - 50	9	15		
51 - 60	1	2		
61 - 70	0	0		
71 - 80	1	2		
81 - 90	0	0		
91 - 100	2	3		

Note: N = 67
Valid Cases = 62

Table 100

Number of Cases During 1986 Involving Cooperation with a Rule 185 County Case Manager by Frequency and Percentage of Response

Number of Cases	Frequency of Responses	Percentage of Responses	*M*	S.D.
0	14	40	4.82	6.4
1 - 2	3	9		
3 - 4	1	3		
5 - 6	9	27		
7 - 8	0	0		
9 - 10	1	3		
11 - 12	1	3		
13 - 14	0	0		
15 - 16	2	6		
17 - 18	0	0		
19 - 20	3	9		

Note: N = 67
Valid Cases = 34

Table 101

Number of Different Rule 185 Case Managers Worked With Whom Rehabilitation Counselors Worked in Past Years by Number and Percentage of Responses

Number of Case Managers	Frequency of Responses	Percentage of Responses	M	S.D.
0	1	4	3.91	2.56
1	3	14		
2	2	9		
3	4	18		
4	5	23		
5	3	14		
6	2	9		
7	0	0		
8	0	0		
9	0	0		
10	2	9		

Note: N = 67
Valid Cases = 22

emphasis by DRS on vocational issues with greater administrative flexibility, while Rule 185 dealt more with long-term services, housing, and medical appointments.

Effectiveness

The next section rated the effectiveness of Rule 185 case managers by function. An earlier item identified a lack of familiarity by most counselors with Rule 185 and thus, less than one-third responded to this section. In overall effectiveness, the 20 respondents indicated that the Rule 185 case managers were moderately effective.

Barriers

Opinions regarding barriers to the effectiveness of case management services generally fell into the category of "seldom a barrier," except for the following where over 50% of the time the named item appeared a problem for the 21 respondents: (a) degree to which case managers will have to interact with other agencies, (b) current caseload size (too many), (c) amount of paperwork, and (d) number of meetings required.

Under staffing barriers, staff shortages and lack of day and residential program options fell into the "often a barrier" category. Lay-offs of case management staff were seldom considered a barrier.

Items under Interagency Administration failed to identify any serious barriers according to the 20 respondents.

Under the topic of Funding, the majority of the 21 respondents felt that insufficient funds was a problem "often" to "always." Over half of these respondents also indicated problems related to restrictions on use of funds and in delays in receiving funds.

The remaining items under "barriers" were split in opinion about whether they were or were not barriers.

Planning

Counselors were asked if they were involved in the development of the individual service plan (ISP). Of the 65 responding, 43% indicated "yes," while 57% said, "no." A branch question followed up on those who responded in the affirmative, requesting the number of clients served. Table 102, Number of Clients for Whom Rehabilitation Counselors Develop an Individual Service Plan, indicates the results. The branch question for those who responded that they are not involved in the development of the individual service plan indicated that 81% of the 26 respondents indicated that they would like to be involved in such a process, while 19% said that they would not.

When asked if the counselors were involved in the individual habilitation plan (IHP), 60 of the 67 responded. Of the valid cases, 18% indicated that they were so involved, while 82% said that they were not. The same branch questions followed. Table 103, illustrating the number of clients whose counselors were involved in the preparation of an IHP, shows that a relatively small number were being served by most of the 10 counselors who had such prior involvement. Of those responding that they had no IHP experience, 32 counselors answered the question of whether they would or would not like to be involved in the IHP. Of this group 66% indicated "yes," while 34% said, "no."

Rehabilitation counselors were asked if during the orientation of new clients they provide information regarding the Department of Human Services case management services. Of the 60 counselors responding, 35% indicated "yes," while 65% said, "no."

Individual Written Rehabilitation Plan

Almost all of the counselors (66) responded to the question regarding whether they contacted the clients, their parents, or their guardians prior to initiation of the individual written rehabilitation plan (IWRP). Of the group, 66% indicated that they always follow this practice, while 33% indicated that they sometimes contact them. None said that they never make such contacts.

Table 102

Number of Clients for Whom Rehabilitation Counselors are Involved in the Individual Service Plan by Frequency and Percentage of Valid Responses

	Frequency and Percentage of Responses				
Number of Clients	f	%	*M*	S.D.	VC
0 - 9	10	54	28.53	40.5	19
10 - 19	3	16			
20 - 29	0	0			
30 - 39	0	0			
40 - 49	1	5			
50 - 99	3	16			
100 - 130	2	10			

Note: N = 67

Table 103

Number of Clients Whose Rehabilitation Counselors Have Been Involved in the Preparation of their Individual Habilitation Plan by Frequency and Percentage of Response

	Frequency and Percentage of Responses				
Number of Clients	f	%	M	S.D.	VC
0 - 9	7	70	23.3	49.85	10
10 - 19	1	10			
20 - 29	0	0			
30 - 39	0	0			
40 - 49	1	10			
50 - 99	0	0			
100 - 149	0	0			
150 - 160	1	10			

Note: N = 67

Counselors were asked how important they feel it is for the client to participate in the IWRP process. Again, 66 responded with 88% indicating that they felt it was "very important" and 20% indicating that it was "important." No one believed that the participation of the client was unimportant.

When asked how often consensus is reached at the end of the IWRP process with a client, 77% of the 66 respondents indicated "always," while 23% said that "sometimes" a consensus was reached.

The branch question which followed attempted to identify the approach a counselor would take when consensus was not reached. The most common response from the 53 who answered the question was "negotiate and compromise," with "discuss appeal process," or "leave the choice up to the client" as the next most commonly ranked responses.

Counselors were asked if they encouraged the clients, the parents, or the guardians to take an active role in procuring, adapting, and arranging the services identified in the IWRP. Of the 66 respondents, 55% indicated that this was "always" done, while 45% indicated that "sometimes" this was their practice.

When asked how counselors monitored the provision of services outlined in the IWRP, the most common responses were: (a) individual evaluation criteria and methods specified on the IWRP are identified and carried out, (b) periodic client interviews, and (c) service provider contacts.

The remaining sections dealt with gaps in services, coordination concerns, and suggestions for improvement. Due to the low number of valid cases and the overlap of suggested items with those previously assessed on the survey, the data did not provide usable information.

Summary

Two important observations could be made from the data. One was that the rehabilitation counselors lacked familiarity with Rule 185 and thus with the whole case management system under the Department of Human Services. The other was that due to a lack of this information and an understanding of the role of the Department of Human Services' case managers, these counselors were unable to inform their clients about such services or to coordinate effectively with that department when clients were shared or referred.

Caseloads for the majority of rehabilitation counselors ranged between 126 and 200 clients with an average of nearly 159 individuals. People with developmental disabilities who were being served clustered between 1 and 50 persons for 67 counselors.

Insufficient funding was cited as a major problem with funding delays and restrictions reported by over half of the respondents. Most rehabilitation counselors did not participate in the development of the IHP. The majority of counselors, however, did involve clients in the IWRP process and gained consensus most of the time.

Advocates

Individuals from a variety of advocacy organizations within the State were asked to respond to the case management survey, since many serve either as case managers or as individuals helping clients with developmental disabilities to gain appropriate service. Thirty-four surveys were completed and returned.

The responses to the question concerning the age levels of persons with developmental disabilities for whom the respondents advocate, indicate their involvement with a wide age range of clients. The respondents could select more than one age range. The greatest number of responding advocates (28) work with more clients in the 22 years and older category, closely followed by those with clients in the age bracket of 6 years to 21 years. The least number of advocates are involved with clients from birth through age five.

Of the 29 respondents, almost 90% of the advocates had achieved an educational level beyond high school (see Table 104). Approximately 55% earned a bachelor's or

Table 104

Highest Educational Attainment Earned by Advocates

Educational Attainment	Frequency of Responses	Percentage of Responses
High school graduate	3	10.3
Bachelor's degree	10	34.5
Master's degree	6	20.7
Specialist certificate	1	3.5
Doctorate	2	6.9
Other	7	24.1

Note. N = 34
Valid cases = 29

master's degree, and 10% held a specialist's certificate or a doctorate. Other degrees earned included Associate of Arts, and nursing degrees.

Advocates were asked if they had taken formal coursework or inservices and workshops in four major areas relating to case management service (see Table 105). The majority of respondents had no coursework in any of the areas, though 35% indicated some formal training in the area of developmental disabilities. In contrast, inservice or workshops had been taken by the majority of advocates in three of the areas. Brokering or negotiating for service was the area in which the fewest advocates had training.

The average length of time the respondents have been advocates was 8.24 years (see Table 106). Over 41 percent have served as advocates for five years or less; slightly more than 48% have been in this field between six and fifteen years; and approximately 10% have been active for over twenty years.

Effectiveness

Table 107 presents a list of case management functions that county managers perform. Advocates were asked to rate the effectiveness, by function, of county case managers who served mutual clients.

With the exception of the intake function which was determined moderately effective (mean of 3.27), the remaining functions appeared to be rated poorly, generally in the "slightly effective" category. The function which was ranked lowest in effectiveness of service delivery was monitoring and follow-up.

Advocates were presented with a list of procedures which they might employ when a client's needs were not being addressed and were asked to check those actions they would take. The most common responses from the 23 who answered the question were: (a) notify the case manager immediately (23 responding), (b) notify the client/guardian (20), and (c) call for an interdisciplinary meeting (15).

Table 105

Overview of Formal Coursework and Inservice or Workshop Training Taken by Advocates

	Formal Coursework				Inservice/Workshop			
Area of Training	f	%	f	%	f	%	f	%
	Yes		No		Yes		No	
Case management	3	8.8	31	91	23	68	11	32
Developmental Disabilities	12	35	22	65	25	74	9	26
Services or brokering/ negotiations	6	18	28	82	8	24	26	76
Individual Habilitation Plan/Individual Service Plan/Individual Educational Plan	7	21	27	79	21	62	13	38

Note. N = 34
Valid cases = 34

Table 106

Length of Time Served as an Advocate

Number of Years	Frequency of Response	Percentage of Response	*M*	S.D.	VC
0	3	10	8.24	6.33	29
1 - 5	9	31.4			
6 - 10	7	24.1			
11 - 15	7	24.1			
20 - 24	3	10.4			

Note. N = 34

Table 107

Effectiveness of Case Management Service Delivery by Function as Assessed by Advocates

Function	1 Not Effective f	%	2 Slightly Effective f	%	3 Moderately Effective f	%	4 Effective f	%	5 Very Effective f	%	Mean	Standard Deviation	Valid Cases
Intake	-	-	5	15.2	16	48.5	10	30.3	2	6	3.27	.80	33
Assessment	5	15.2	10	30.3	16	48.5	1	3	1	3	2.49	.91	33
Planning	4	12.1	18	54.5	6	18.2	5	15.2	-	-	2.36	.90	33
Coordination	5	15.2	15	45.5	9	27.2	4	12.1	-	-	2.36	.90	33
Development of IHP	8	24.2	12	36.4	11	33.3	2	6.1	-	-	2.21	.89	33
Record-keeping	3	9.4	8	25	14	43.8	6	18.8	1	3	2.81	.97	32
Support	6	18.2	15	45.5	9	27.2	3	9.1	-	-	2.27	.88	33
Linking and Brokering	5	15.6	12	37.5	13	40.6	2	6.3	-	-	2.38	.83	32
Monitoring/ Follow-up	11	33.3	9	27.3	11	33.3	2	6.1	-	-	2.12	.96	33
Discharge	4	13.3	10	33.3	7	23.3	8	26.7	1	3.4	2.73	.11	30
Advocacy	6	18.2	9	27.3	13	39.4	5	15.1	-	-	2.52	.97	33
Counseling	5	15.6	12	37.5	13	40.6	2	6.3	-	-	2.38	.83	32

Note. N = 34.

When asked about the gaps in the provision of case management services to persons with developmental disabilities, advocates gave a wide array of responses. The major problems listed fell into the categories of inservice and training in case management, information on services available in the community, communication and coordination among agencies and direct service providers and the ability to recognize and meet client needs.

Training

An extensive list of topics which relate to case management duties was provided to the advocates. Table 108 lists in descending order the topics advocates feel are necessary for the continuing education of case managers. All of the 28 respondents indicated the need for case managers to identify the goals, preferences, strengths, and needs of the client and to monitor the quality of services received. The second two most popular responses were methods for creative problem-solving and assisting the clients to become their own service coordinators. Advocates could identify more than one topic and thus the total exceeds 100%.

Summary

Generally, advocates had limited coursework in case management, but did have some inservice experience in developmental disabilities and case management. Most of the case management functions were rated poorly by the advocates with the exception of intake. Notable gaps in service were felt to be lack of inservice and lack of information and coordination with service providers.

Public Health Nurses

Education and Training

Thirty public health nurses (PHN) responded to the survey on case management. Table 109, Occupational Title and Employment Settings of Public Health Nurses, illustrates the results of the question concerning education and background.

Table 108

Advocates' Opinions Regarding Case Managers' Training Needs

Training Topics	Frequency of Response	Percentage of Response
Identify clients' needs	28	82.4
How to monitor client services	28	82.4
Creative problem solving	25	78.1
Assist clients in becoming their own service coordinators	25	78.1
Analysis of client information and development of ISP agreement	23	67.6
Participation in individual planning process	23	67.6
Legal rights and protection of clients	21	61.8
How to broker services	20	58.8
History, normalization, values	18	52.9
Methods to facilitate the team consensus process	18	52.9
Negotiating with service providers	16	47.1
Information on developmental disabilities	16	47.1
Relating to agencies	15	44.1
Assisting/referring clients in crisis	15	44.1
Gaining information on service options	14	41.2
Identifying all pertinent information related to client needs	13	38.2
Procuring and analyzing intake data re: client eligibility for service	12	35.3

Note. N = 34

Table 109

Occupational Title and Employment Settings of Public Health Nurses

Occupational Title	f	%
Director	10	33
PHN	12	40
Supervisor	4	13
Case Manager	1	3
Other	3	10
Employment Setting	**f**	**%**
County Public Health Agency	26	87
County Social Services	2	7
Other	2	7

Note. N = 30
Valid cases = 30

Professional certification or licensure held by the majority (97%) was Public Health Nurse; 86% also held a registered nurse (RN) license.

Twenty-nine of the 30 public health nurses responded to the question regarding whether they were qualified mental retardation professionals (QMRP) under the Medicaid ICF-MR regulations. Of the respondents, 41% indicated that they were so qualified, while 59% indicated that they were not.

Responding to the question of highest educational degree attained, 93% of the nurses indicated that they held a baccalaureate degree; 7% of the 30 nurses held a master's degree.

Table 110, Number of College Courses Taken in Case Management and Year Attended Before and After Employment for Public Health Nurse Case Managers, indicates that most nurses took no courses regarding case management prior to employment as well as after they were employed. A similar question was posed regarding college courses taken in the field of developmental disabilities. The valid cases included less than a third of the responding public health nurses and thus the data did not appear to be significant.

The mean number of years which public health nurses served in a case manager role was 3.5 years, while the mean number of years for working with persons with developmental disabilities was 2.5 years. Table 111, Number of Years in Case Manager Roles and Number of Years Serving Persons with Developmental Disabilities, shows the results.

Case Load

Table 112 describes the number of individuals with developmental disabilities served by age group by the public health nurses (PHN). Most commonly, public health nurses served between one and 10 persons with developmental disabilities from every age group listed.

Table 110

Number of College Courses Taken in Case Management and Year Attended Before and After Employment for Public Health Nurse Case Managers

Courses Taken	f	%	VC	MC	Number of Courses	f	%	VC	MC
Before Employment:									
Courses Taken < 1969									
0	28	100	28	2	0	26	93	28	2
					1	2	7		
Courses Taken < 1970-80									
0	27	96	28	2					
1	1	4							
Courses Taken > 1981									
0	26	96	27	3					
1	1	4							
After Employment:									
Courses Taken < 1969									
0	29	100	29	1	0	26	90	29	1
1	0	0			1	1	3		
					2	1	3		
					3	1	3		
Courses Taken < 1970-80									
0	29	100	29	1					
1	0	0							
Courses Taken > 1981									
0	25	89	28	2					
1	1	4							
2	1	4							
3	1	4							

Note. N = 30

VC = Valid cases. MC = Missing cases.

Table 111

Number of Years in a Case Manager Role and Number of Years Serving Persons with Developmental Disabilities

Number of Years as Case Manager	f	%	M	S.D.	Number of Years Serving Persons with Developmental Disabilities	f	%	M	S.D.
0	9	30	3.57	3.87	0	12	40	2.5	3.52
1	1	3			1	3	10		
2	1	3			2	3	10		
3	5	17			3	4	13		
4	6	20			4	2	7		
5	3	10			5	3	10		
6	2	7			6	1	3		
8	1	3			8	1	3		
13	1	3			17	1	3		
17	1	3							

Note. N = 30
Valid Cases Years as Case Manager = 26
Valid Cases Years Serving Persons with Developmental Disabilities = 30

Table 112

Persons with Developmental Disabilities Currently Served by PHN by Age Group

Age Group	Number of Persons	Frequency	Percentage	Valid Cases	M	S.D.
Birth - 5 yrs	0	3	13.1	23	6.57	9.12
	1-10	17	74			
	11-20	1	4.3			
	21-30	1	4.3			
	31-40	1	4.3			
6 yrs - 21 yrs	0	6	37.5	16	1.88	1.89
	1-5	10	62.5			
22 yrs - 30 yrs	0	7	50	14	2.29	4.03
	1-5	6	42.86			
	6-10	0	0			
	11-15	1	7.14			
31 yrs - 60 yrs	0	3	21.42	14	3.14	5.64
	1-15	10	71.44			
	16-30	1	7.14			
> 60 yrs	0	2	15	13	10.08	19.26
	1-10	8	62			
	11-20	2	15			
	21-50	0	0			
	51-70	1	8			

Note. N = 30

Responses to categorical definition of disabilities being served required some research on the part of the public health nurse and thus there were fewer responses to this item. Of the client disabilities accounted for in all age groups, there were 22 with mental retardation, 16 with cerebral palsy, 4 with Down syndrome (which may have been counted again under mental retardation), 3 with speech and language problems, 3 adults with mental illness, and 35 with assorted other disabilities.

When asked about preference for clients with or without developmental disabilities in their case load, 7% of the 28 respondents had no preference, 4% indicated that they preferred 100% of the client load to be people with developmental disabilities, and 89% indicated that they would prefer a mixture -- clients both with and without developmental disabilities.

Table 113 lists the number of persons with developmental disabilities served in 1986 by the nurses. The majority served one to 20 clients with developmental disabilities.

To the question of how many persons with developmental disabilities were removed from the PHN case load due to the fact that they no longer needed health care management, 19 responded. Of the group, 57% had no clients removed, one nurse had 20 removed, and the others had small numbers (1-5) removed.

Because of the small number of valid cases on items which asked for the length of time spent serving clients with developmental disabilities, there were no significant findings.

Table 114 illustrates the number of nondisabled clients served by the public health nurse case manager. The range was 0 to 750 with the most frequent responses clustering between 21 and 40 clients. The high mean and standard deviation reflect the exceptionally high case loads of a small number of nurses.

In order to gain better case load information, another table was developed to show side-by-side comparisons of numbers of clients with and without developmental disabilities

Table 113

Persons with Developmental Disabilities Served by Public Health Nurses During 1986

Number of Persons	Frequency of Response	Percentage	*M*	S.D.
0	2	9.5	16.52	20.8
1-10	9	43		
11-20	5	23.8		
21-30	1	4.7		
31-50	3	14.3		
51-80	1	4.7		

Note. N = 30
Valid Cases = 21
Missing Cases = 9

Table 114

Nondisabled Clients Served by a PUblic Health Nurse Case Manager

Number of Nondisabled Clients	Frequency of Response	Percentage of Response	*M*	S.D.
0	2	8	104.32	200.64
1 - 20	4	16		
21 - 40	11	44		
41 - 60	3	12		
61 - 100	1	4		
101 - 200	1	4		
201 - 400	1	4		
401 - 750	2	8		

Note. N = 30
Valid Cases = 25
Missing Cases = 5

(see Table 115). The mean number of clients with developmental disabilities per case load was approximately 15 persons. In reviewing the data, it was noted that 38% of the case load of persons with developmental disabilties fell into the birth to five year age group. In some cases, public health nurse respondents indicated that school nurses typically took responsibility for the school-aged (6-21 years) age group.

Barriers

Public health nurses were asked to respond to a list of potential barriers to the delivery of case management services (see Table 116). Those considerations where the majority indicated "often" to "always a barrier" were (a) the amount of paperwork required of case managers (74%), and (b) the amount of time needed to interact with other agencies (67%). The area which indicated the least problem appeared to be travel time/distance to the client's residence with 79% falling in the "seldom" to "never a barrier" categories.

Case Management Functions

The next set of questions addressed the initial procedures employed by the nurses when receiving new clients with developmental disabilities. When asked if they orient the clients, their parents or guardians to case management services, 92% said "yes," while 8% said that they do not provide such orientation. When asked if they specifically explain the case management process to the clients, parents or guardians, 54% indicated that they did, while 46% said that they did not. On both of these items, 24 of the 30 nurses responded. When asked if the public health nurse explains to the client, parents, or guardian that if they are not satisfied with current services, they may request another case manager, 43% indicated that they provide this explanation, while the greater percentage, 57% indicated that they do not. Twenty-three nurses responded to this item. The procedure of contacting the clients prior to the service plan review meeting to discuss the meetings was employed by 65% of the public health nurses, but was not

Table 115

Composition of Public Health Nurses' Caseloads by Number and Percentage of Clients with Developmental Disabilities (DD) and Those Who were Non-developmentally Disabled (NDD)

Number of Clients		Total	Percentageage DD	Percentage of DD Population Served by Age Group			
DD	Non-DD			Birth - 21 years	Adults	*M* DD Clients Per Caseload	Valid Cases
60	0	60	100	5	95	15.52	26
0	30	30	0	-	-		
14	10	24	58	71	29		
1	20	21*	5	0	100		
9	200	209	4	78	22		
0	2	2**	0	-	-		
2	30	32**	6	100	0		
1	30	31	3	100	0		
3	31	34	9	67	33		
76	-	76	100	92	8		
13	13	26	50	77	23		
7	33	40	18	57	43		
13	68	81	16	77	23		
13	41	54	24	100	0		
13	28	41**	32	15	85		
2	25	27	7	100	0		
50	40	90	56	80	20		
9	35	44	20	44	56		
16	50	66	24	81	19		
3	23	26	12	100	0		
3	50	53	6	100	0		
12	350	362	3	83	17		
10	40	50	20	50	50		
55	750	805**	7	0	55		
3	11	14	21	-	100		
388	1,910	2,298					

Note. N = 30

*Also conducts screenings for 212 clients

**Director respondents (Some of these figures may represent agency totals)

Table 116

Opinions Regarding Barriers to Delivery of Case Management Services

Potential Barriers	1 Never a Barrier f	 %	2 Seldom a Barrier f	 %	3 Often a Barrier f	 %	4 Almost always a Barrier f	 %	5 Always a Barrier f	 %	M	S.D.	VC	NC
Client's level of disability	5	22	7	30	11	48	-	-	-	-	2.26	.81	23	7
Service providers	-	-	10	43	8	35	5	22	-	-	2.78	.80	23	7
Available training information	2	8.3	12	50	8	33.4	-	-	2	8.3	2.5	.98	24	6
Lack of family involvement	1	4.2	11	45.8	9	37.5	3	12.5	-	-	2.58	.78	24	6
Amount of time needed to interact with other agencies	1	4	7	29	11	46	4	17	1	4	2.88	.9	24	6
Travel time/distance to client residence	6	25	13	54	4	17	-	-	1	4	2.04	.91	24	6
Case manager's current client caseload	2	8	9	58	9	38	2	8	2	8	2.71	1.04	24	6
Amount of paperwork required of case managers	-	-	6	25	10	41.7	5	20.8	3	12.5	3.21	.98	24	6
Number of meetings case managers are required to attend	4	16.7	10	41.6	7	29.2	3	12.5	-	-	2.38	.92	24	6

Note. N = 30

typical of 35% of the 23 respondents. When asked how important it is for the client to participate in the service plan review meeting, 7% failed to respond and 93% indicated that they felt it was very important to have such participation. Of the 30 public health nurses, 27 responded to this item. Regarding how often consensus is reached at the end of the service plan reviews, 19% of the 27 respondents failed to answer the question, while 48% indicated that sometimes a consensus is reached and 33% indicated that consensus is always reached.

The next section dealt with responsibilities of the public health nurse as he/she saw them and whether these "should be" his/her responsibilities. Table 117 illustrates the responses. The majority felt that the itemized statements were part of his/her responsibility, and although there was some variation in the first four items between "is" and "should be," the consensus remained that these duties should be the case manager's responsibility.

When asked if clients, parents, and guardians are aware that they may take an active role in procuring, adapting, and arranging the services in the service plan, 58% of the 26 respondents indicated that they usually knew, 35% said that they sometimes knew, and 4% said that they seldom knew that they could participate. One failed to answer the question (4%). The mean (1.39) fell between "usually" (1.0) and "sometimes" (2.0), with a standard deviation of .637.

Table 118 illustrates responses to items regarding how the service plan is monitored. For most items, the majority indicated that the listed procedures were employed. The only item which seemed to hold some controversy was holding an annual review with only 52% feeling that this was their responsibility.

Table 119 describes what procedures the public health nurses employ when a client with disabilities has need of a service and the service is unavailable. The consensus of the public health nurses was that postponing writing the need into the service plan when

Table 117

Responsibilities of Public Health Nurse Case Managers Serving Persons with Developmental Disabilities

Responsibility Statements	Currently PHN responsibility						Should be PHN responsibility					
	frequency		percentage				frequency		percentage			
	Yes	No	Yes	No	VC	MC	Yes	No	Yes	No	VC	MC
Ensure that the service plan review meeting is held	17	5	77	23	22	8	13	3	81	19	16	14
Ensure that plan update is jointly developed	20	2	91	9	22	8	14	2	88	13	16	14
Ensure that client's views are heard and integrated into plan	22	2	92	8	24	6	16	0	100	0	16	14
Advocate for client when he/she disagrees with team	23	1	96	4	24	6	13	2	87	13	15	15
Write the plan document and distribute it to client and team members	15	6	71	29	21	9	12	5	71	29	17	13

Note. N = 30

Table 118

Procedures Employed by PHN to Monitor Progress of the Service Plan

Procedure	Frequency Yes	Frequency No	Percentage Yes	Percentage No	VC	MC
Visit client at service sites while services are being provided	23	2	92	8	25	5
Review service providers' records and reports	22	3	88	12	25	5
Hold periodic client interviews	21	4	84	16	25	5
Hold periodic family interviews	23	2	92	8	25	5
Hold annual review meeting	13	12	52	48	25	5
Revise individual service and habilitation plans as needed	24	1	96	4	25	5

Note. N = 30
VC = Valid Cases. MC = Missing Cases.

Table 119

Procedures Employed by PHN When Service is Unavailable to Client

Procedure	Frequency Yes	Frequency No	Percentage Yes	Percentage No	Valid Cases	Missing Cases
Write the need into the individual service plan (ISP)	17	9	65	35	26	4
Postpone writing need into ISP until services are available	7	19	27	73	26	4
Recommend appropriate alternatives	25	1	96	4	26	4
Set date to review alternative service needs	21	5	81	19	26	4
Assign someone to develop needed services	18	7	72	28	25	5
Notify proper authorities of gap in services	23	3	88	12	26	4
Wait until annual review meeting	2	22	8	92	24	6
Schedule a review meeting	12	12	50	50	24	6

Note. N = 30

services were not available was not an appropriate procedure, nor was waiting until an annual review meeting to address the concern.

The next section asked about the case management functions performed by the public health nurses and the estimated monthly percentage of time based on a full-time equivalent (FTE) (see Table 120). The majority of public health nurses performed the listed case management functions with the greatest percentage of time dedicated to: assessment, recordkeeping, planning, and coordination. The least amount of time was devoted to discharge and advocacy functions. Valid cases were higher (24-25) on the yes-no items than on the estimated percentages of time devoted to each function (16-19 respondents).

Effectiveness

The effectiveness of the public health case management delivery system was rated by the public health nurses by function (see Table 121). The majority ranked assessment, planning, intake, coordination and support "effective" to "very effective" on the scale, while linking and brokering and developing the IHP ranked lowest, but the means were still within the "moderately effective" range. In overall effectiveness, the majority of public health nurses indicated that the system was effective. It is interesting to note that assessment, planning, and coordination were areas which demanded a high percentage of the case manager's time and were also the highest ranked in effectiveness.

Non-Case Management Functions

When public health nurses were asked if they had job responsibilities not related to case management, 86% (28 valid cases) indicated "yes," while 14% said "no." A series of follow-up questions sought to identify the specific "other responsibilities" of these case managers.

Supervision of other public health nurses was a responsibility of 76% of the 25 respondents. Administrative inservice training was a duty of 57% of the 21 respondents.

Table 120

Case Management Functions Performed by PHN and Estimated Monthly Percentage of Time Spent Per Function

Function Performed	Frequency Yes	No	Percentage Yes	No	VC	Range of Estimated Percentage of Time Per Function	M of Percentage of time per function	S.D. of time per function	Valid Cases	Missing Cases
Intake	21	4	84	16	25	0 - 30	5.0	6.68	19	11
Assessment	23	2	92	8	25	0 - 30	11.33	7.69	18	12
Planning	22	2	92	8	24	0 - 40	9.5	9.17	16	14
Coordination	20	4	83	17	24	0 - 50	9.28	11.48	18	12
Develop IHP	19	5	79	21	24	0 - 20	6.56	5.48	18	12
Record-keeping	23	2	92	8	25	0 - 30	9.94	8.19	17	13
Support	21	3	88	13	24	0 - 15	5.35	4.68	17	13
Linking and Brokering	20	4	83	17	24	0 - 10	4.0	3.45	18	12
Monitoring/ Follow-up	21	3	88	13	24	0 - 25	7.0	6.28	18	12
Discharge	21	3	88	13	24	0 - 10	3.06	2.58	18	12
Advocacy	19	5	79	21	24	0 - 15	3.33	3.61	18	12
Counseling	20	4	83	17	24	0 - 15	4.59	4.18	17	13

Note. N = 30.

Table 121

Effectiveness of Case Management Service Delivery by Function

	1 Not Effective		2 Slightly Effective		3 Moderately Effective		4 Effective		5 Very Effective			
	f	%	f	%	f	%	f	%	f	%	*M*	S.D.
Intake	-	-	-	-	2	8	16	67	6	25	4.17	.57
Assessment	-	-	1	4	1	4	7	29	15	63	4.5	.78
Planning	-	-	-	-	2	8	13	54	9	38	4.29	.62
Coordination	-	-	-	-	6	25	9	38	9	38	4.13	.80
Develop IHP	-	-	3	13	6	25	10	42	5	21	3.71	.96
Recordkeeping	-	-	1	4	9	38	7	29	7	29	3.83	.92
Support	-	-	1	4	5	21	9	38	9	38	4.08	.88
Linking and brokering	2	8	4	17	7	29	8	33	3	13	3.25	1.15
Monitoring/ Follow-up	-	-	1	4	6	25	10	42	7	29	3.96	.86
Discharge	-	-	1	4	6	25	10	42	7	29	3.96	.86
Advocacy	1	4	1	4	6	25	10	42	7	29	3.96	1.12
Counseling	-	-	1	5	1	5	17	77	3	14	4.0	.6

Note. N = 30
Valid cases = 26. Missing cases = 4.

Administrative paperwork not related to client recordkeeping, and responsibilities for public education were typical duties of 92% of the 25 respondents. Outreach efforts consumed a portion of the time for 83% of 24 case managers and 88% indicated that identifying resources for clients was another time-consuming responsibility.

Training

Some of the areas in which over 50% of the responding public health nurses felt they needed additional training are: (a) legal rights and steps necessary to protect those rights; (b) methods of creative problem-solving and innovative thinking; (c) identifying the client's personal goals, preferences, strengths, and needs; (d) how to assist clients in becoming their own case managers; (e) how to relate to and work with various participating agencies; (f) methods to gain emergency or crisis services for clients; (g) methods of facilitating the team consensus process; (h) how to function as a broker of service; (i) methods of negotiating with clients and service providers when the client disagrees with individual plan components; (j) monitoring the quality of service to clients; and (k) general information on developmental disabilities.

This last section of the survey indicates a great need for inservice training in the common areas of case management function for public health nurses.

Summary

Generally, public health nurses who were surveyed indicated a relatively small caseload of clients with developmental disabilities (1-20 clients). The major barriers cited to effective case management were the amount of paperwork and the time needed to interact with other agencies. There appeared to be some need for public health nurses to detail the case management process for parents/guardians and clients and to advise them of their rights. Assessment, planning and coordination were the most time-consuming portions of the public health nurses' responsibilities and were ranked most effective. Most nurses had job responsibilities unrelated to case management which consumed much of their time, including supervision. Generally, the public health nurses were satisfied with the effectiveness of the case management system, but over half indicated a need for more training.

CHAPTER SIX

Summary and Discussion

Over the past several years greater numbers of persons with developmental disabilities are being served in communities, increasing the need for coordination of appropriate services. Case management systems have been challenged to provide the needed coordination of services that will facilitate the achievement of independence, productivity, and community integration for persons with developmental disabilities. In Minnesota, counties are largely responsible for providing services coordination, or case management, to citizens with developmental disabilities.

For purposes of this study, a commonly accepted definition of "case management" was used. The Developmental Disabilities Assistance and Bill of Rights Act of 1975 (P.L. 95-602) has defined "case management services" as: " . . . such services to persons with developmental disabilities as will assist them in gaining access to needed social, medical, educational, and other services." This term includes follow-along and coordination services as well.

The Minnesota University Affiliated Program (MUAP) conducted an extensive survey to collect data from multiple sources for the purpose of describing current case management practices in Minnesota, identifying barriers to and gaps in services, and obtaining perceptions of the effectiveness of case management services. Survey questionnaires were mailed to nine different target groups: (1) directors of county human services agencies, (2) county case manager supervisors, (3) county case managers, (4) consumers, (5) service providers, (6) school personnel, (7) rehabilitation counselors, (8) advocates, and (9) public health nurses. The combined input of these target groups provided information to respond to the research questions.

Procedures and Response Rates

A survey instrument was developed by MUAP staff and presented for review to the Advisory Committee. Nine groups were targeted for receipt of the questionnaire. A total of 1,771 surveys were sent and 770 forms were completed and returned. The overall response rate among the nine target groups was 43% with a higher average response rate (67%) for human services personnel, the primary target group. A telephone follow-up was conducted to improve the initial response to the survey. Data were collated by target groups and significant findings were incorporated into a written report.

Current Status of Case Management Practices

Minnesota is divided into 87 counties. These counties, either singly or through combined effort, have 81 county human services agencies which are largely responsible for case management services to Minnesota citizens with developmental disabilities. There are 81 directors of county human service agencies, 125 supervisors of county case managers, 291 county case managers, and approximately 15.5 (FTE) case management aides in Minnesota all working toward providing case management services.

Education and Background of Human Services Personnel

Most of the county case managers and supervisors have baccalaureate degrees in social work, with psychology and sociology also being common academic majors. An overwhelming majority of supervisors and case managers had no formal training in case management prior to employment; however, most of the supervisors, and only a few of the case managers, have attended inservice training sessions to gain case management skills. Fewer than 50% of the supervisors and 30% of the case managers have had courses in developmental disabilities either prior to or after being employed, although a significant majority of both groups have received information on developmental disabilities through inservice training experiences.

Apparently, most of the training received by case management personnel has occurred after employment and through inservice activities. This finding indicates that case management personnel have acquired knowledge and skills over a period of time during which they are working with persons with developmental disabilities. The scope and comprehensiveness of training may be questionable when it is acquired through a series of unrelated workshops and conferences. It appears from these results that preservice training programs would be well-advised to revise their curriculum offerings, focusing on the needs of graduates and preparing them adequately for the requirements of jobs in the current market. It is important to note that directors and supervisors indicated that the least amount of cooperative work exists between county agencies and universities compared to relationships counties have with other agencies. Advocates also expressed concern regarding adequate training for case managers.

Staffing Patterns

Most of the county human services agencies (88%) do not have supervisors of county case managers probably because over half of the counties have only one or two case managers, and most of the directors and supervisors agreed that optimally there should be one supervisor for every six to eight case managers. Prior to becoming a supervisor, most (72% of those responding) were case managers, but most supervisors do not currently carry a caseload. Over half (60%) of the case managers do not have case management aides, and 25% (45 case managers) have only 40 minutes to 10 hours of this assistance per week. Six case managers (3.2%) have most of the case management aide time.

Case Load

Generally, county case managers serve adult clients more frequently than they serve children and youth from birth to 21 years of age, although 85% of the case managers responding indicated that they do serve some school-age children and youth. Since school systems also provide case managers for students with disabilities, this finding implies that some students receive services from more than one case manager. How, or whether, these services are coordinated between the two agencies was not determined; however, directors indicated moderate to much cooperation between county human services agencies and school districts, leading to the speculation that there is at least some coordination between these agencies. Most of the consumers who responded to the survey said that they received case management services after age 21; almost none received services during the preschool years.

It was found that the range in case load size for county case managers was exceptionally wide: 16 to 241 clients. The range of clients with developmental disabilities was 8 to 196. Fifty-five percent of the total number of respondents (192) indicated that they also serve clients who do not have developmental disabilities. The mean number of clients served with developmental disabilities was over 55 persons and the total client case load averaged over 68. This finding indicates that client case loads are more than double the recommended ratio of 1:30 (one case manager to 30 clients). Seventeen percent of case manager supervisors also carried a case load in addition to their supervisory responsibilities. The range in client numbers for these supervisors (15) was 1 to 95 with a mean of over 37 clients.

Information obtained from case managers indicated that only a very small number, or none, of their clients are discharged from their case loads because they no longer need services, suggesting that once a person with developmental disabilities enters the case management system he/she remains within that system for a long period of time. The ultimate objective when working toward the goal of independence is to prepare clients to become their own case managers. When asked if they inform clients/parents/guardians that they may take an active role in the case management process, 87% of the case managers felt that they do so; however, they indicated that only about 58% of their clients and their families actually did assume an active role in the process.

Of the consumers and their families who responded to the survey, 39% felt that they could be their own case managers, while 61% felt that they could not. This occurrence might be partly due to the fact that clients and their families may not have the skills necessary to become actively involved, but could, with appropriate training, move more rapidly toward assuming some active role in seeking coordination of their own services. Preparing clients to become their own case managers or to assume some of the responsibilities, might also eventually lead to more discharges, or at least to less intensive work on the part of the case manager, thus reducing his/her workload, or equally important, increasing the effectiveness of securing and coordinating needed services.

Over half of the case managers in Minnesota serve 11 to 25 clients who have been assigned I.Q. scores below 35 with 1 to 10 of these clients also exhibiting behavior problems. For another client group with I.Q. scores above 35 points, case managers also reported that from 1 to 10 such persons on their case loads also exhibited behavior problems. Such clients generally require greater time in planning, providing, and monitoring appropriate community services which increases the workload of the case manager without increasing client numbers. Nevertheless, over half of the case managers preferred that 100% of their client caseload be persons with developmental disabilities, and another 46% indicated that they preferred a client mixture. This finding indicates that county case managers are willing to work with persons with developmental disabilities even though they probably have not been well-prepared to do so in their preservice and inservice training.

The information obtained from this section of the questionnaire supports the finding from the section on barriers which indicates that client case load size is a significant barrier to the delivery of effective case management services. Heavy case loads combined with increased amounts of paperwork account for the highest ratings in the barrier section for directors, supervisors, and case managers, and were among the factors indicated as major concerns among the target groups of consumers, service providers, and rehabilitation counselors. Of the consumers who responded to the survey, 54% stated that their case manager spent an average of only about 20 minutes a month with them, with the highest amount of average monthly time reported as being 4.5 hours.

Extent of Case Management Services

Case managers in Minnesota are providing services to approximately 15,000 persons with developmental disabilities out of an estimated total of 41,900 persons with developmental disabilities in the state population. (This estimated figure is based on a prevalence rate of 1%.)* However, approximately 84% of the directors' group and the supervisors' group indicated that all persons with developmental disabilities who were eligible for services were receiving them. Eighty-eight percent of both groups stated that no waiting list of persons with developmental disabilities existed. These two groups also indicated that the intake function of case managers was performed very effectively. Of the few directors and supervisors who acknowledged having a waiting list, the majority also said that their agencies provided interim services. The majority of the small number of consumers who responded to the survey also indicated that they did not have to wait for services or for needed changes in services.

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*About 38% of the population with developmental disabilities is being served by counties. Some of the people not being served by counties are receiving services from school systems, but it could not be determined how many.

Case Management Functions

The majority of case managers appear to accept the listed functions, (which were derived from those mandated in Rule 185), as necessary case management tasks even though they reported experiencing an inordinate amount of paperwork and meetings. A large majority of case managers indicate that they respect clients' rights and wishes by giving them appropriate orientation to case management services, including them in planning meetings, advocating for them, and in reaching consensus at these meetings. An overwhelming number of case managers (83 to 97%) reported that they follow adequate procedures for monitoring the progress of the ISP. These procedures include site visits, reviewing service providers' records and reports, interviewing clients, holding review meetings, and revising plans when necessary. The majority of consumers and their families seemed to agree, indicating a level of satisfaction with services received. The most significant discrepancy appeared in the area of "preparing the client for the planning meeting" with most of the case managers indicating they did so, but with 42% of the consumers indicating that they were not adequately prepared. While respondents indicated some degree of satisfaction in meeting case management functions, highly rated problem areas regarding caseloads, paperwork and meetings would suggest that insufficient time may be available for developing, coordinating, and monitoring services.

Case Management Time Allocation

A majority of case managers reported spending 70-100% of their time on case management functions with recordkeeping, coordination, and planning requiring the most amount of time. Monitoring and developing IHPs required the next largest amount of time; other functions were reported as requiring less than 8% of their time. Advocacy for their clients, which most case managers felt they did well, occupied slightly less than 5% of their time, and counseling, which is generally perceived as being a major function of social workers, occupied slightly less than 5.5% of the case managers' time. If university programs are emphasizing the development of counseling skills in their preparation of social workers, they may be over-preparing their students, at least those who become case managers, with a skill that is needed only occasionally in the reality of the workplace. When case managers indicated their training needs, they rated developing negotiation skills, skills in creative and innovative problem-solving, and planning skills as their three highest priorities.

Cooperative Work Between Agencies

Items on the directors and supervisors questionnaires addressed the current level of cooperative work existing between agencies and a projection of what should exist. In the opinion of members of these two target groups, the agencies with which the most cooperative work existed were residential providers, developmental activity centers, and sheltered workshops, both groups indicating the need for even more cooperation. A moderate amount of cooperation appears to exist between county agencies and mental health centers, local school districts, and rehabilitation services with the perceived ideal being that considerably more cooperation should exist. Slight to moderate cooperative work exists between the county agencies and the Department of Human Services, with both groups indicating that the level of cooperation should be considerably higher. Since the Department of Human Services (DHS) is ultimately responsible for the quality of case management services in the state, and since regional supervisors and a program coordinator are employed by DHS, this could be an important area of future analysis. The DHS, for example, has recently designated full-time staff resources to direct and coordinate training and technical assistance services to local county case managers. It should be noted that the question did not ask for a rating on the amount of contact between agencies but on the level of cooperation. Other agencies with which a somewhat less than moderate cooperative level exists are social security, community agencies, volunteer advocacy associations, and the criminal justice system. The lowest ratings were assigned to area vocational technical institutes and universities. Supervisors and directors thought that higher levels of cooperation should exist with all agencies.

It appears that county agencies maintain the highest level of cooperation with those agencies that provide direct services to their clients. Most of the service providers indicated that they worked with from 1 to 15 different county case managers, while 6% reported that they worked with as many as 36 to 46 case managers. Many of these case managers probably represented different counties, since most service providers reported working with from 1 to 24 counties. Case managers occasionally share clients with school case managers and rehabilitation counselors, and while the current level of cooperation with these two agencies is rated as "slight" to "moderate," county personnel feel that a much higher level would be more productive. It is interesting to note that although rehabilitation counselors and county case managers sometimes have common clients, most of the counselors were unaware of the functions performed by case managers. By understanding what each professional can offer to a common client, it would seem that more appropriate service and habilitation plans could be developed and implemented. The lowest ratings (none to slight) were assigned to area vocational technical institutes and universities. In light of the discussion under the section on education and background, it is obvious that if county case management personnel are to be better prepared to perform case management functions, educational institutions and county agencies must work together to develop a higher level of cooperation and communication.

Evaluation

There does not seem to be a standard evaluation form or procedure for evaluating case managers; rather, each county establishes its own guidelines. The survey results indicate that most case managers are evaluated once a year either by supervisors or directors. The performance standards most commonly used are job descriptions, the DHS

Merit form, and the achievement of previously established goals and objectives for each case manager. Supervisors are generally evaluated by their county directors. Most of the counties in Minnesota evaluate only the performance of individuals on their case management staff and do not evaluate the overall effectiveness of the case management system, with slightly fewer than half of the counties indicating that they perform a systems evaluation. Without such an evaluation, counties would not have access to information necessary to make decisions concerning policy and future planning, or in identifying trends that might suggest staffing or procedural changes. A lack of such evaluation suggests that many counties are operating on a reactive basis rather than collecting information for future planning and operating from a proactionary perspective.

Only one-third of the service providers who responded to the survey indicated that they were ever involved in evaluating case management services. Since they are such an integral part of the case management process, they should be able to supply pertinent information on how the process could be improved. Perhaps more importantly, 94% of the consumers who responded indicated that they had never been asked to evaluate case management services. Until it is determined how a product affects consumers, it is extremely difficult to plan future changes that would produce more effective services.

In summary, case management functions in Minnesota are outlined in Rule 185 which was developed by the Department of Human Services, Division for Persons with Developmental Disabilities. County human services agencies, responsible for the case management systems within each county or groups of counties, are trying to follow the mandates of Rule 185 and, at the same time, are attempting to deal with some of the obstacles that accompany it. Many of the county case managers have not been prepared to perform the functions required in this rule. These functions have precipitated a shift from the traditional social worker role to that of case manager which requires, among other things, that case managers communicate and work cooperatively with numerous individuals and agencies. Individual counseling and advising aspects are diminished, and team planning, negotiation, and coordination are emphasized. During the process of change, many case managers have attempted to get more training; however, most of this training has been comprised of unrelated workshops and conferences.

The case management process also involves more paperwork, as documentation is an obvious necessity, and more meetings, many of which must now involve a substantial number of individuals, including the consumer and family who also must be prepared for the meetings. The case manager's role has become more complex at a time when staff shortages exist, thereby making decreased case load sizes unfeasible.

Most counties do not appear to view their case management services from a systems perspective which might provide insight if they did so, on ways to deliver services in a more economical and efficient manner. The greatest problem currently facing case managers seems to be the delivery of increased and more effective services while struggling with large case loads.

Barriers

County directors, supervisors, case managers, and rehabilitation counselors identified what they perceived as barriers to the delivery of effective case management services. The counselors were asked to respond on the basis of observations when serving mutual clients with county case managers. These groups consistently identified heavy case loads, a large amount of paperwork, and the great number of meetings as being serious barriers. Other factors which all agreed acted as serious barriers included: (1) staff shortages, (2) lack of residential program options, (3) insufficient funds, and (4) restrictions in the use of funds. None of the groups perceived county administration or interagency administration factors as barriers to the delivery of effective services, nor did they perceive their client's disability level to be a barrier. Public health nurses identified two serious barriers to their delivery of case management services: amount of paperwork and time needed to interact with other agencies. Interestingly, only one of the groups (supervisors) felt that staff turn-over was a serious barrier even though it has been listed as a problem for other groups of people who work in direct service roles with persons with developmental disabilities (Lakin, et al. 1982).

In summary, the four factors perceived to be the most serious barriers to the delivery of effective case management services are not, on the surface, complex problems and all correspond directly to the factor of funding. If case manager to client ratios could be reduced by adding needed staff, more attention could be devoted to performing the functions considered essential to the case manager's role. Moreover, efforts to reduce or consolidate paperwork may also deserve some attention. However, currently, insufficient funds may preclude the hiring of additional staff even if qualified people were available. The availability of appropriate service options, particularly residential service options, was also noted as a serious barrier. Several counties are using Home and Community Based Waiver funds to create innovative residential options for persons with developmental disabilities; perhaps more counties should explore this and other innovative methods to develop less traditional and more appropriate living arrangements for their clients.

Gaps and Duplications in Case Management Services

The items requesting identification of gaps and duplications in case management services did not produce definitive results. Several seemed to feel that the gaps that existed were caused by the "system," particularly funding problems which caused delays in services. Specifically, consumers felt that gaps which resulted in reduced services were caused by: (1) case managers not getting to know their clients and client needs, (2) heavy caseloads, and (3) lack of knowledge of available resources. Many of the respondents listed "barriers" under this item, and those have been discussed in a previous section.

Few duplications were identified. However, duplication in paperwork and in the individual service plan and the individual habilitation plan were cited several times.

These items were open-ended questions which may account for the few responses, or it could be that most respondents did not feel that significant gaps and duplications exist in current case management practices.

Effectiveness of Case Management Services

All of the target groups were requested to rate the effectiveness of case management services by function. Generally, supervisors, case managers, and directors ranked these services higher than advocates, service providers and rehabilitation counselors, although only a low percentage (33%) of the latter group responded to this item. School personnel and public health nurses rated their own case management services rather than those of the counties.

Case Management in Schools

Public school personnel ranked their provision of case management services as effective (4 on a 5-point Likert scale) with developing individual education plans as the function they performed most effectively. Screening, assessment, and coordination functions also were assigned high ratings. The functions receiving the lowest ratings were counseling, support, and interagency activities. Most of the school personnel responding to the survey were teachers and, thus, their primary responsibility is teaching. Case management duties are a secondary responsibility, and the inability to leave the classroom during the day would significantly decrease the amount of time teachers could spend in counseling activities and in participating in interagency planning and cooperation.

Public Health Case Management Services

Public health nurses rated their provision of case management services as "effective" to "very effective" and gave extremely high ratings to the functions of intake, assessment, and planning. The areas in which they felt least effective were recordkeeping and linking and brokering. Public health nurses ranked their services higher than school personnel ranked school services and higher than any group ranked county case management services. One factor influencing this rating might be caseload size. The majority of public health nurses responding to the survey had caseloads consisting of 1 to 10 persons with developmental disabilities.

County Case Management Services

County supervisors' ratings on the effectiveness of case management services were the highest, with directors and case managers rating them second and third highest, respectively, as compared to the other target groups that rated these services (advocates, service providers, rehabilitation counselors, and consumers). Supervisors and directors generally perceived advocacy and intake functions as being performed very effectively. Supervisors also gave the functions of assessment, counseling, support, and planning high ratings. The majority of directors (except on the two functions previously mentioned) and case managers rated all of the functions as moderately effective to effective. Case managers and directors perceived recordkeeping as the least, though still moderately, effective function. Supervisors rated IHP development as the lowest, yet still moderately, effective function, and case managers also indicated concern that this function might be performed effectively with 69% rating it as not effective to moderately effective. Over half of the case managers also rated linking and brokering and monitoring within the same range.

Service providers' and advocates' perceptions of the effectiveness of case management services were not as high as those of county personnel, reflecting an overall rating of slightly to moderately effective. They rated the intake process as the most effective function and IHP development as the least effective ("not effective" to "slightly effective"). Service providers and advocates also felt that linking and brokering, support, coordination, and planning were only minimally effective.

Consumers' opinions of the effectiveness of the case management services they received were more similar to those of county personnel than those of service providers and advocates. Generally, when ranking case management services by function, they found them to be helpful (M = 3.0 - 3.7), and when ranking overall case management helpfulness, the mean was 3.3, indicating consistency in their perceptions.

County personnel and consumers seem to be in agreement in their perceptions of the effectiveness of case management services, however, advocates and service providers clearly have a lower opinion of the effectiveness of case management services.

Factors and Strategies that Contribute to Effective Case Management

The review of literature highlighted a number of factors that positively influence the effectiveness of case management. Studies identified effective leadership (Randolph et al., 1984; Wray et al., 1985), workable case manager to client ratios (Rosenau & Totten, 1983), improved communication among case management agencies and other agencies, and reduced paperwork (Wray et al., 1985) as objectives whose accomplishment would lead to better case management services. Providing relevant training for case managers, clients, families, and advocates (Human Development Program, 1983; Wray et al., 1985), supportive work environments, and task clarity (Randolph et al, 1984) also were cited as strategies for improving case management services. Carragone (1984) suggested that relevant training for case managers should shift from training for traditional social work services roles to training for the newer conceptual scope of case management. In the shift from traditional services to case management services, service settings change from office-oriented, fixed appointment models to locations where clients live, work and receive services. Emphasis is placed on interagency coordination and systems of influence rather than focusing only on client behaviors.

In the current study, these same factors and strategies were identified by most of the target groups as the factors that needed to be improved in order for case management services to become more effective.

Recommendations

An obvious recommendation for improving case management services in Minnesota concerns the development of improved and relevant training programs. Appropriate preservice training is extremely important and the university setting should be the trainee's first opportunity to receive consistent and comprehensive philosophy, information, and skills development. Most of the county case managers have received their professional preparation in social work programs which generally, in Minnesota, do not prepare students to work as case managers with individuals with developmental disabilities. In general, social work programs continue to train students for traditional social work roles rather than for roles as service coordinators (Carragone, 1984). The Department of Human Services, Division for Persons with Developmental Disabilities, counties, and universities should implement a cooperative effort toward improving preservice training programs to eliminate the necessity of case managers receiving a fragmented education after employment. Inservice training for case managers should be better coordinated so that workshops will be offered on a consistent basis and, over time, will present comprehensive philosophy, information, and skills development for case managers in the field. Currently, the logical source for the administration, planning, and delivery of such inservice training is the Department of Human Services, Division for Persons with Developmental Disabilities, which should work cooperatively in this effort with counties and other agencies. The Division has undertaken a training program of similar scope, but its implementation has been so recent that no evaluation information is available on its impact.

The issue of staff shortages must be addressed. Almost all groups indicated that heavy caseloads and too much paperwork were significant barriers to the delivery of case management services. If case managers are to perform all case management functions efficiently, they will need to have fewer clients or more support. Additional case management aides and computerized documentation programs may be a partial solution. More consumers and families performing as their own case managers, at least for some functions, may offer some relief, but before this can occur individuals, groups, or agencies will have to train consumers and their families so that they can develop the necessary skills in a comfortable manner.

The Governor's Planning Council on Developmental Disabilities is aware of such problems inherent in the current case management system. In response to these concerns, a set of priorities was developed and requests for proposals were sent to service delivery agencies serving persons with developmental disabilities in 1986. Two of the projects funded by the Council on Developmental Disabilities were the Consumer Empowerment Project which has been training families to serve as case managers for the family member with developmental disabilities, and a Data Integration Project which is piloting a computerized system for recording and documenting the planning, service delivery, and monitoring processes for individuals receiving case management services. These appear to be promising approaches designed to reduce the impact of some of the barriers identified in this survey study.

County human service agencies should work toward developing more cooperative relations with other agencies whose responsibilities directly and indirectly affect services available to their clients. The directors and supervisors indicated that they are already aware of this need and probably need only to find the time to begin the communication.

County directors and supervisors, perhaps in cooperation with the Department of Human Services, should consider developing and implementing a case management system evaluation plan in addition to the evaluation they currently do of case management personnel. Included in the plan should be procedures for gaining evaluation information from consumers and other individuals and agencies involved in the case management process. An evaluation of the system should provide a broader perspective and it might provide insights into more efficient ways to deliver services.

In summary, case management in Minnesota appears to be struggling to provide needed services coordination to persons with developmental disabilities. The general perception of case management seems to be that it is moderately effective in providing such services. The four most critical areas to address immediately if services are to become more effective are: (1) training, (2) funding, (3) staff shortages, and (4) evaluation. As the problems within these areas are resolved, persons with developmental disabilities should receive more effective case management services that will enable them to become fully integrated into their communities.

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APPENDIX A

CASE MANAGEMENT RESEARCH PROJECT

ADVISORY COMMITTEE

CASE MANAGEMENT RESEARCH PROJECT
ADVISORY COMMITTEE

RoseAnn Faber
Minnesota Governor's Planning Council on
Developmental Disabilities

Mr. Larry Wefring
DD Council, UAP Committee

Ms. Toni Lippert, Program Manager
Metro Region Developmental Disabilities
Program - Metropolitan Council

Mr. Jerry Mueller, Executive Director
Minnesota Developmental Achievement
Center Association

Ms. Barbara V. O'Grady, Director
Ramsey County Public Health Nursing
Services

Ms. Dorothy Peters, Ed.D.
DD Council, UAP Committee, Chair

Barbara Polister
Parent

Jan Rubenstein
Washington County Developmental Learning
Center, Inc.

William Niederloh, Assistant Commissioner
Rehabilitation Services

Duane Shimpach
Faribault-Martin-Watonwas Human Services
Board

Mr. Ed Skarnulis, Director
Mental Retardation Division
Department of Human Services

Ms. Karen
DD Council, UAP Committee

Barb Troolin
Special Education Section
State Department of Education

Dr. Colleen Wieck, Executive Director
Governor's Planning Council on
Developmental Disabilities

Alternates:

Shirley Schue
Case Management Coordinator
Mental Retardation Division

Ron Kaliszewski
Governor's Planning Council on
Developmental Disabilities

APPENDIX B

COVER LETTERS FOR CASE MANAGEMENT SURVEY

MINNESOTA
UAP
University
Affiliated
Program

Minnesota University Affiliated Program
on Developmental Disabilities

Dedicated to improving the quality and community orientation of professional services and social support provided to developmentally disabled persons and their families.

University of Minnesota • 6 Pattee Hall • 150 Pillsbury Drive S.E. • Minneapolis, MN 55455 • (612) 624-4848
Gillette Children's Hospital • 200 E. University Avenue • St. Paul, MN 55101 • (612) 291-2848, ext. 226

May 18, 1987

Director:
Robert H. Bruininks, Ph.D.
University of Minnesota
Associate Director:
Richard P. Nelson, M.D.
Gillette Children's Hospital
Training Coordinator:
Patricia McAnally, Ph.D.
University of Minnesota
Services Coordinator:
Georganne Farseth, Ph.D.
Gillette Children's Hospital
Information/Dissemination/ Research Coordinator:
K. Charlie Lakin, Ph.D.
University of Minnesota
Community Liaison:
Eunice Davis, M.D., M.P.H.
Gillette Children's Hospital
Assistant to Director for Administration:
Sharon Olson
University of Minnesota
Assistant to Director for Administration/Evaluation:
Martha L. Thurlow, M.A.
University of Minnesota

Dear Case Manager:

The University Affiliated Program on Developmental Disabilities (UAP) is conducting an extensive survey of case management in Minnesota under a grant award from the Governor's Planning Council on Developmental Disabilities. The purpose of this survey is to obtain current information about case management services that are available to persons with mental retardation or other related conditions, to identify barriers encountered by case managers in their work, and to identify training needs of case managers.

There is a genuine need for accurate information about case management practices with individuals with mental retardation or other related conditions. We need your help in developing this information. The survey questionnaire is long, but we hope that will not keep you from completing and returning it. Note that the questions are on both sides of the page. Most of the items can be answered by checking a response or circling a number. Please take the time to respond. This is information that only you can give us, and we hope the compilation and analysis will be beneficial to you in your work and to persons with mental retardation or other related conditions. Your responses on the questionnaire will be treated with strict confidence and summarized in ways which ensure that you or your individual agency cannot be identified. Your agency will receive a summary of the survey results to share with you.

As a small token of our appreciation, when we receive your completed survey, we will mail you a $20.00 coupon which can be applied toward the registration fee for the Case Management Conference in September. We will be reporting these survey results during one of the conference sessions.

We sincerely appreciate your cooperation in completing and returning the questionnaire.

Sincerely,

Pat McAnally
Pat McAnally
Training Coordinator

Department of Educational Psychology, College of Education

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Community Liaison:
Eunice Davis, M.D., M.P.H.
Gillette Children's Hospital
Assistant to Director for Administration:
Sharon Olson
University of Minnesota
Assistant to Director for Administration/Evaluation:
Martha L. Thurlow, M.A.
University of Minnesota

June 12, 1987

Dear Survey Recipient:

We have not yet received your response to the survey on Case Management which was sent out the end of May. The information and perceptions which you can provide are very important to the validity of the survey results, and we would like to include your responses.

We realize that you have a very busy schedule and that there is always more than enough paperwork to do. We encourage you to spend a few minutes to complete the survey, however, as we feel that the results of this survey will have a significant impact upon Case Management services in Minnesota.

If you have misplaced the survey which was sent to you, we would be happy to send you another one. We can be contacted at the above address or phone number. If this letter reaches you after you have sent your survey in, please accept our thanks.

We would appreciate receiving your responses by Friday, June 26, so that we may begin to analyze the data. Thank you again for your assistance. Have a great summer.

Sincerely,

Pat McAnally
Pat McAnally

APPENDIX C

SAMPLE CASE MANAGEMENT SURVEYS FOR:

C-1 * Directors of Human Service Agencies

C-2 * Case Manager Supervisors

C-3 * Case Managers

C-4 * Consumers

C-5 * Service Providers

C-6 * School Personnel

C-7 * Rehabilitation Counselors

C-8 * Advocates

C-9 * Public Health Nurses

CASE MANAGEMENT SURVEY

Directors of County Welfare and Human Services Agencies

Date: ____________

1. How many case manager supervisors (FTE) work in your county agency? ______

2. How many case managers (FTE) work in your county agency? ______

3. How many case aides (FTE) work in your county agency? ______

4. In your opinion, what is the optimal ratio of supervisors to case managers? ______

5. Have case management services been provided to all persons with developmental disabilities (mental retardation or other related conditions) meeting your criteria for service? 1 Yes ___ 2 No ___

6. Do you have a waiting list for persons with developmental disabilities in need of case management services? 1 Yes ___ 2 No ___

7. If yes, are these persons presently provided with interim services outside of the case management system? 1 Yes ___ 2 No ___

8. Listed below are factors which have been suggested as possible barriers to the successful delivery of case management services. Using the following scale, please indicate the degree to which these factors act as barriers to the provision of case management services in your agency.

1	2	3	4	5
Never a barrier	Seldom a barrier	Often a barrier (about 50% of the time)	Almost always a barrier	Always a barrier

A. GENERAL CONSIDERATIONS

a. Client's level of disability a. ________

b. Service Providers b. ________

c. Experience/expertise of case manager c. ________

d. Degree of family involvement d. ________

e. Degree to which case manager will have to interact with other agencies e. ________

f. Travel time/distance to client residence f. ________

g. Case manager's current client caseload size g. ________

h. Amount of paperwork required of case managers h. ________

i. Number of meetings case managers are required to attend i. ________

j. Other: Please specify j. ________

B. STAFFING

a. Staff shortages ________
b. Staff turnover ________
c. Reduction in force (layoffs) of management staff ________

C. AVAILABILITY OF PROGRAMS

a. Lack of residential program options ________
b. Lack of day program options ________
c. Lack of other program options or service options ________
d. Difficult access for the client with developmental disabilities to generic agency programs/services ________

D. FUNDING

a. Insufficient funds
b. Delays in receiving funds for client services ________
c. Restrictions in use of funds ________

E. COUNTY ADMINISTRATION

a. Lack of routine planning and coordination within own agency ________
b. Coordination between program units ________
c. Internal reorganization ________

F. INTER-AGENCY ADMINISTRATION

a. Lack of routine planning and coordination among service providers for a client at the local level a. ________
b. Difficulty in communication among agencies at the local level b. ________
c. Confidentiality issues that inhibit flow of necessary information on clients c. ________
d. Lack of information or understanding about other agencies' programs, resources, and problems d. ________
e. Inappropriate referrals e. ________
f. Duplication of services f. ________
g. Multiple individual plans for a single client g. ________
h. Clients "falling into the cracks" between agencies h. ________
i. Lack of clear understanding of which agency is responsible for client's case management i. ________
j. Multiple case managers/ client coordinators for a single client j. ________

9. Using the following scale, please indicate the degree of cooperative work between your agency and these agencies in your part of the state.

1	2	3	4
None	Slight	Moderate	Much

	WHAT EXISTS	WHAT SHOULD BE
A. Department of Human Services	________	________
B. School District	________	________
C. Local Office of Rehabilitation Services	________	________
D. Mental Health Centers	________	________
E. Criminal Justice System	________	________

F. DAC ________ ________

G. Residential Providers ________ ________

H. Sheltered Workshops ________ ________

I. Voluntary Advocacy Agencies (e.g., ARC, UCP) ________ ________

J. Community Associations (i.e., religious, clubs, etc.) ________ ________

K. Social Security ________ ________

L. University ________ ________

M. AVTI ________ ________

N. Other________________________________ ________ ________

10. Below is a list of case management functions. In your opinion, how effective is the case management service delivery provided by your agency for each service function? (Use the following scale).

1	2	3	4	5
Not Effective	Slightly Effective	Moderately Effective	Effective	Very Effective

a. INTAKE. Determining a client's eligibility for services. 1 2 3 4 5

b. ASSESSMENT. Ascertaining a client's strengths and specific needs for service. 1 2 3 4 5

c. PLANNING. Developing the individual service plan. 1 2 3 4 5

d. COORDINATION. Serving as a focal point for service. Coordinating among the diverse providers of services required by an individual. 1 2 3 4 5

e. DEVELOP the Individual Habilitation Plan. Developing a written plan of needs and goals for the individual client. 1 2 3 4 5

f.	RECORDKEEPING. Maintaining comprehensive written records regarding intake information, strengths and needs assessment, goal and routine service planning, staff action, client progress and case review.	1	2	3	4	5
g.	SUPPORT. Helping the individual and/or his/her family with unanticipated crisis intervention.	1	2	3	4	5
h.	LINKING AND BROKERING. Referral or development of services as outlined in the Individual Habilitation Plan. This may include arranging for services at generic agencies, accompanying client to agencies, assist in completing forms or other activities which ensure that the client is linked to new services.	1	2	3	4	5
i.	MONITORING/FOLLOW-UP. Assuring that the client is receiving appropriate services as outlined in their Individual Habilitation Plan and periodically reassessing the individual client's progress.	1	2	3	4	5
j.	DISCHARGE. Terminating those services no longer needed or for which the client is no longer eligible.	1	2	3	4	5
k.	ADVOCACY. Protecting and upholding the rights of the client.	1	2	3	4	5
l.	COUNSELING. Talking with clients about issues, such as alternative service availability, risk and benefit, etc.	1	2	3	4	5
m.	OVERALL EFFECTIVENESS	1	2	3	4	5

11. What gaps do you see in your case management system for people with developmental disabilities?

12. What duplications do you see in your case management system for people with developmental disabilities?

13. How often do you evaluate your case managers?
What criteria and performance standards do you use?

Please enclose or comment on what instrument/procedure you use for performance evaluation.

14. Do you evaluate the effectiveness of the case management system in your county?
1 2
Yes ___ No ___

Please enclose or comment on what instrument/procedure you use.

15. Was your case management turnover rate (January 1986 - December 1986) high enough to be considered a barrier to effective case management services?
1 2
Yes ___ No ___

If yes, what could be done to reduce case management turnovers?

16. **What other agencies/professionals perform case management services in your county? Please list.**

17. In your opinion, should the State of Minnesota apply for Medical Assistance Funding for case management under the Consolidated Omnibus Budget Reconciliation Act (COBRA)?

1	2
Yes ___	No ___

THANK YOU FOR YOUR ASSISTANCE!

If we have questions about your responses, may we call you? If yes, may we have the following information? Your name, phone number, and responses will be kept confidential.

Name of person completing survey: ______________________________

Phone Number: _______________

CASE MANAGEMENT SURVEY

Case Manager Supervisors

Date: ________________

1. What is your educational background?

major(s)	degree(s)	
	a. Baccalaureate	________
	b. Masters	________
	c. Doctorate	________
	d. Other	________

2. Were you a county case manager before you became a case manager supervisor?

1 Yes ___ 2 No ___

3. Did you have any college courses which provided training in case management? (Please list under appropriate heading.)

Before employment as case manager supervisor	Year course was taken

After employment as case manager supervisor	Year course was taken

4. What specific college courses have you had in the field of developmental disabilities (mental retardation or other related conditions)? (Please list under appropriate heading.)

Before employment as case manager supervisor	Year course was taken

After employment as case manager supervisor	Year course was taken

5. What inservice training experiences have you had that increased your knowledge/skills in case management and mental retardation or other related conditions? Please list the topics of the training experiences and the year in which you attended them.

Topics	Year

6. How many years have you been a case manager supervisor? In what settings? 6. ________

   a. county ________
   b. day program ________
   c. Department of Rehabilitation Services ________
   d. Other (Please specify) ________________

7. How many case manager supervisors work in your agency? 7. ________

8. How many case manager supervisors do you think there should be? 8. ________

9. What is the average number of case managers assigned to you? 9. ________

10. Do you carry a client caseload? 10. 1 Yes ___ 2 No ___

11. What is the typical or most frequent size of your client caseload? 11. ________

12. Have case management services been provided to all persons with mental retardation or other related conditions meeting your agency's criteria for service? 12. 1 Yes ___ 2 No ___

13. Does your agency have a waiting list for persons with mental retardation or other related conditions in need of case management services? 13. **Yes** (1) ___ **No** (2) ___

14. If yes, are these persons presently provided with interim services outside of the case management system? 14. **Yes** (1) ___ **No** (2) ___

15. Listed below are factors which have been suggested as possible barriers to the successful delivery of case management services. Using the following scale, please indicate the degree to which these factors act as barriers to the provision of case management services.

1	2	3	4	5
Never a barrier	Seldom a barrier	Often a barrier (about 50% of the time)	Almost always a barrier	Always barrier

A. GENERAL CONSIDERATIONS

a. Client's level of disability a. ________

b. Service Providers b. ________

c. Lack of experience/expertise of case manager c. ________

d. Lack of family involvement d. ________

e. Degree to which case manager will have to interact with other agencies e. ________

f. Travel time/distance to client residence f. ________

g. Case manager's current client caseload size g. ________

h. Amount of paper work required of case managers h. ________

i. Number of meetings case managers are required to attend i. ________

j. Other (Please specify) __________ j. ________

B. STAFFING

a. Staff shortages a. ________

b. Staff turnover b. ________

c. Reduction in force (layoffs) of case management staff c. ________

C. AVAILABILITY OF PROGRAMS

a. Lack of residential program options a. ________

b. Lack of day program options b. ________

c. Lack of other program/service options c. ________

d. Difficult access for clients with mental retardation or other related conditions to generic agency programs/services d. ________

D. FUNDING

a. Insufficient funds a. ________

b. Delays in receiving funds for client services b. ________

c. Restrictions in use of funds c. ________

E. COUNTY ADMINISTRATION

a. Lack of routine planning and coordination within own agency a. ________

b. Coordination between program units b. ________

c. Internal reorganization c. ________

F. INTER-AGENCY ADMINISTRATION

a. Lack of routine planning and coordination among service providers for a client at the local level a. ________

b. Difficulty in communication among agencies at the local level b. ________

c. Confidentiality issues that inhibit flow of necessary information on clients c. ________

d. Lack of information or understanding about other agencies' programs, resources, and problems d. ________

e. Inappropriate referrals e. ________

f. Duplication of services f. ________

g. Multiple individual plans for a single client g. ________

h. Clients "falling into the cracks" between agencies h. ________

i. Lack of clear understanding of which agency is responsible for client's case management i. ________

j. Multiple case managers/client coordinators for a single client j. ________

16. Using the following scale, please indicate the degree of cooperative work between your agency and these other agencies in your area.

1 None	2 Slight	3 Moderate	4 Much

			What exists	What should be
A.	Department of Human Services	A.	________	________
B.	School District	B.	________	________
C.	Local Office of Rehabilitation Services	C.	________	________
D.	Mental Health Center	D.	________	________
E.	Criminal Justice System	E.	________	________
F.	DAC	F.	________	________
G.	Residential Providers	G.	________	________
H.	Sheltered Workshops	H.	________	________
I.	Voluntary Advocacy Agencies (e.g., ARC, UCP)	I.	________	________
J.	Community Associations (i.e., religious, clubs, etc.)	J.	________	________

K.	Social Security	K.	________	________
L.	University	L.	________	________
M.	AVTI	M.	________	________
N.	Other ________________	N.	________	________

17. Below is a list of ten case management functions. In your opinion, how effective is the case management service delivery provided by your agency for each service function? (Use the following scale).

1	2	3	4	5
Not Effective	Slightly Effective	Moderately Effective	Effective	Very Effective

a.	INTAKE. Determining a client's eligibility for services.	1	2	3	4	5
b.	ASSESSMENT. Ascertaining a client's strengths and specific needs for service.	1	2	3	4	5
c.	PLANNING. Developing the individual service plan.	1	2	3	4	5
d.	COORDINATION. Serving as a focal point for service. Coordinating among the diverse providers of services required by an individual.	1	2	3	4	5
e.	DEVELOP the Individual Habilitation Plan. Developing a written plan of needs and goals for the individual client.	1	2	3	4	5
f.	RECORDKEEPING. Maintaining comprehensive written records regarding intake information, strengths and needs assessment, goal and routine service planning, staff action, client progress and case review.	1	2	3	4	5
g.	SUPPORT. Helping the individual and/or his/her family with unanticipated crisis intervention.	1	2	3	4	5

h.	**LINKING AND BROKERING.** Referral for new services as outlined in the Individual Habilitation Plan. This may include arranging for services at generic agencies, accompanying client to agencies, assisting in completing forms or other activities which ensure that the client is linked to new services.	1	2	3	4	5
i.	MONITORING/FOLLOW-UP. Assuring that the client is receiving appropriate services as outlined in their Individual Habilitation Plan and periodically reassessing the individual client's progress.	1	2	3	4	5
j.	DISCHARGE. Termination of those services no longer needed or for which the client is no longer eligible.	1	2	3	4	5
k.	ADVOCACY. Protecting and upholding the rights of the client.	1	2	3	4	5
l.	COUNSELING. Talking with clients about issues such as alternative service availability, risks and benefits, etc.	1	2	3	4	5
m.	OVERALL EFFECTIVENESS	1	2	3	4	5

18. What gaps do you see in your case management system for people with mental retardation or other related conditions?

19. What duplication do you see in your case management system for people with mental retardation or other related conditions?

20. How often do you evaluate your case managers? ____________
What criteria and performance standards do you use?

Please enclose or comment on what instrument/procedure you use for performance evaluation.

21. By whom is your effectiveness as a case management supervisor evaluated?

22. Was your case manager turnover rate (January 1986-December 1986) high enough to be considered a barrier to effective case manager services? Yes ______ No ______

If yes, what could be done to reduce case management turnovers?

23. Thinking of your role as a supervisor, in which of the following topics do you feel you have a current need for more training? (Check those that apply.)

________ a. Information on history, normalization, values.

________ b. How to identify client's personal goals, preferences, strengths, and needs.

________ c. Methods for creative problem solving and for thinking innovatively.

________ d. Legal rights of clients and steps necessary to protect those rights.

________ e. How to assist clients and families in becoming their own service coordinators.

________ f. How to relate to and work with the various participating agencies.

________ g. Methods to assist and refer clients in crises or emergency situations.

________ h. How to procure and analyze intake data to determine client eligibility for service coordination.

________ i. How to identify all pertinent information related to the client.

________ j. How to analyze initial client information and develop an individual service plan with the client.

________ k. How to function as a broker of services.

________ l. Methods to facilitate the team consensus process.

________ m. How to participate effectively in the individual planning process.

________ n. Methods for procuring accurate information related to service options to meet individual client needs.

________ o. Methods for negotiating with clients and service providers when the client disagrees with individual plan components.

________ p. How to participate in periodic client reviews.

________ q. How to monitor quality of service to individual clients.

________ r. General information on developmental disabilities (mental retardation and other related conditions).

________ s. Other - please specify

Now, go back over the list and circle your check marks to indicate the three areas in which you believe it is most important that you receive training.

THANK YOU!

If we have questions about your responses, may we call you? If yes, may we have the following information? Your name, phone number, and responses will be kept confidential.

Name of person completing survey: ____________________

Phone Number: ____________

CASE MANAGEMENT SURVEY

Case Managers

Date: ____________

Job Preparation/Experience

1. What is your educational background?

major(s)	degree(s) (please check)	
	a. Baccalaureate	_____
	b. Masters	_____
	c. Doctorate	_____
	d. Other	_____

2. Did you have any college courses which provided training in case management?

Course	Year the course was taken

3. What specific college courses have you had in the field of developmental disabilities (mental retardation or other related conditions)?

Course	Year the course was taken

4. What inservice training experiences have you had that increased your knowledge/skills in case management and developmental disabilities (mental retardation or other related conditions)? Please list the topics of the training experiences and the year in which you attended them.

5. How long have you been a case manager? Years _____ Months _____
In what settings?

a. county ____________
b. day program __________
c. Department of Rehabilitation Services __________
d. other (please specify) ____________________________________

6. How long have you been a case manager working with people with mental retardation or other related conditions? Years _____ Months _____
In what settings?

a. county __________
b. day program ____________
c. Department of Rehabilitation Services __________
d. other (please specify) ____________

7. Are you a qualified mental retardation professional (QMRP) as stipulated in Medicaid ICF/MR regulations?

1	2	3
Yes ___	No ___	Don't Know ___

8. Please list areas in which you hold current professional licensure/certification.

9. What is your job title? ____________________
What is the name of your agency? ____________________

Population: Persons with Mental Retardation and Other Related Conditions

10. For how many persons with mental retardation or other related conditions are you currently the case manager? Include in your answer persons for whom case aides may perform some or most of the case management responsibilities.

Age Groups	Number
Preschool (Birth - 5 years)	_____
School-Age (6 years - 21 years)	_____
Adult (over 21 years)	_____
Total:	_____

11. For the total number of persons with mental retardation or other related conditions that you serve, how many have an I.Q. score that is below 35? ______

    a. Of these individuals, how many also have significant behavior problems? ______

12. For the total number of persons with mental retardation or other related conditions who have an I.Q. score of 35 or above, how many also have significant behavior problems? ______

13. If you were able to choose the makeup of your caseload, which would you prefer?

    a. 100% clients with mental retardation or other related conditions a. ______
    b. Some, but not all, clients with mental retardation or other related conditions b. ______
    c. No clients with mental retardation or other relation conditions c. ______

14. How many persons with mental retardation or other related conditions were removed from your caseload in 1986 because they no longer needed case management services? ______

15. Of the persons with mental retardation or other related conditions currently on your caseload, how many have you served for:

less than 1 year	______
1 to 5 years	______
5 to 10 years	______
10+ years	______

16. How much case aide time is currently provided to you to assist in management of your case load for persons with mental retardation or other related conditions? State your answer in terms of all or a portion of a full-time equivalent position or positions. ______

Other populations served with Case Management Services

17. How many clients do you serve on your caseload who do not have mental retardation or other related conditions? ______

Barriers

18. Please indicate the degree to which these factors act as barriers to your delivery of quality case management services:

1	2	3	4	5
Never a barrier	Seldom a barrier	Often a barrier (about 50% of the time)	Almost always a barrier	Always a barrier

A. GENERAL CONSIDERATIONS

a. Client level of disability a. ________

b. Service providers b. ________

c. Lack of training/information on what you as a case manager should do c. ________

d. Lack of family involvement d. ________

e. Amount of time needed to interact with other agencies e. ________

f. Travel time/distance to client residence f. ________

g. Your current client caseload size g. ________

h. Paperwork h. ________

i. Too many meetings i. ________

j. Other: Please specify__________________ j. ________

B. STAFFING

a. Staff shortages a. ________

b. Staff turnover b. ________

c. Reduction in force (layoffs) of case management staff c. ________

C. AVAILABILITY OF PROGRAMS

a. Lack of residential program options a. ________

b. Lack of day program options b. ________

c. Lack of other program/service options c. ________

d. Difficult access for clients with mental retardation or other related conditions to generic agency programs/services d. ________

D. FUNDING

a. Insufficient funds a. ________

b. Delays in receiving funds for client services b. ________

c. Restrictions in use of funds c. ________

E. COUNTY ADMINISTRATION

a. Lack of routine planning and coordination within own agency a. ________

b. Coordination between program units b. ________

c. Internal reorganization c. ________

F. INTER-AGENCY ADMINISTRATION

a. Lack of routine planning and coordination among service providers for a client at the local level a. ________

b. Difficulty in communication among agencies at the local level b. ________

c. Confidentiality issues that inhibit flow of necessary information on clients c. ________

d. Lack of information or understanding about other agencies' program, resources, and problems d. ________

e. Inappropriate referrals e. ________

f. Duplication of services f. ________

g. Multiple individual plans for a single client g. ________

h. Clients "falling into the cracks" between agencies h. ________

i. Lack of clear understanding of which agency is responsible for client's case management — i. ________

j. Multiple case managers/client coordinators for a single client — j. ________

Job Functions

19. When orienting persons with mental retardation or other related conditions on your caseload, do you always:

		1	2
a.	Orient them, their parents, or guardians to case management services?	a. Yes ___	No _____
b.	Specifically explain the case management process to them?	b. Yes ___	No ___
c.	Inform them that they have the opportunity to request another case manager if they are not satisfied with your services?	c. Yes ___	No ___
d.	Contact them prior to their service plan review meeting to discuss this meeting with them?	d. Yes ___	No ___

20. How important do you feel it is for the client to participate in the individual service plan review meeting?

a. not important ___
b. somewhat important ___
c. very important ___

21. How often is consensus reached at the end of the service plan reviews you participate in?

a. never ___
b. sometimes ___
c. always ___

22. For each of the following statements, indicate if you feel it reflects a current responsibility of yours as a case manager serving persons with mental retardation or other related conditions. In the second column, indicate if you feel it should be your responsibility as a case manager:

		is my responsibility	should be my responsibility
a.	Ensure that the individual service plan is written	1. Yes ___ 2. No ___	3. Yes ___ 4. No ___

b.	Ensure that the service plan review meeting is held	1. Yes ___ 2. No ___	3. Yes ___ 4. No ___
c.	Ensure that the resulting plan update is developed jointly by those invited	1. Yes ___ 2. No ___	3. Yes ___ 4. No ___
d.	Ensure that the client's views are heard and integrated into the plan	1. Yes ___ 2. No ___	3. Yes ___ 4. No ___
e.	Advocate for the client when he/she disagrees with the rest of the team	1. Yes ___ 2. No ___	3. Yes ___ 4. No ___
f.	Write the revised plan document and distribute it to client and team members	1. Yes ___ 2. No ___	3. Yes ___ 4. No ___

23. Do your clients/parents/guardians know that, if they are able, they may take an active role in procuring, adapting and arranging the services identified in the individual service plan?

1 Never	2 Seldom	3 Sometimes	4 Usually	5 Always
________	________	________	________	________

24. How often do your clients/parents/guardians take an active role in procuring, adapting and arranging the services identified in the individual service plan?

1 Never	2 Seldom	3 Sometimes	4 Usually	5 Always
________	________	________	________	________

25. How do you monitor the progress and appropriateness of the individual service plan and the individual habilitation plan? Do you:

			1	2
a.	visit the client at the service sites while services are being provided?	a.	Yes ___	No ___
			1	2
b.	review service providers' records and reports	b.	Yes ___	No ___
			1	2

c.	hold periodic client interviews	c. Yes ___	No ___
		1	2
d.	hold periodic family interviews	d. Yes ___	No ___
		1	2
e.	hold annual review meeting	e. Yes ___	No ___
		1	2
f.	revise individual service and habilitation plans as needed	f. Yes ___	No ___
		1	2
g.	other (please specify) ________________	g. Yes ___	No ___

26. When you have identified a service need for your client with mental retardation or other related conditions, but the needed service is unavailable, do you:

		1	2
a.	write the need into the ISP?	a. Yes ___	No ___
		1	2
b.	postpone writing the need into the ISP until services are available?	b. Yes ___	No ___
		1	2
c.	recommend appropriate alternatives?	c. Yes ___	No ___
		1	2
d.	set date to review alternative service needs?	d. Yes ___	No ___
		1	2
e.	find/assign someone to develop needed services?	e. Yes ___	No ___
		1	2
f.	notify the proper authorities of the gap in services?	f. Yes ___	No ___
		1	2
g.	wait until the annual review meeting?	g. Yes ___	No ___
		1	2
h.	schedule a review meeting?	h. Yes ___	No ___

27. What percentage of your time is spent on case management (based on 100%)? ______

28. Considering only the time you spend on case management, please indicate below the case management functions you typically perform and estimated monthly percentage of case management time (during an average month) you spend on each function. (These percentages should equal 100% and should not include non-case management time).

			1 YES	2 NO	EST %TIME
a.	INTAKE. Determining a client's eligibility for services.	a.	______	______	______
b.	ASSESSMENT. Ascertaining a client's strengths and specific needs for service.	b.	______	______	______
c.	PLANNING. Developing the individual service plan.	c.	______	______	______
d.	COORDINATION. Serving as a focal point for service. Coordinating among the diverse providers of services required by an individual.	d.	______	______	______
e.	DEVELOPING Individual Habilitation Plan. Developing a written plan of needs and goals for the individual client.	e.	______	______	______
f.	RECORDKEEPING. Maintaining comprehensive written records regarding intake information, strengths and needs assessment, goal and routine service planning, staff action, client progress and case review.	f.	______	______	______
g.	SUPPORT. Helping the individual and/or his/her family with unanticipated crisis intervention.	g.	______	______	______

h. LINKING AND BROKERING. Referring for or developing new services as outlined in the individual habilitation. plan. This may include arranging for services at generic agencies, accompanying client to agencies, assisting in completing forms or other activities which ensure that the client is linked to new services. h. ______ ______ ______

i. MONITORING/FOLLOW-UP. Assuring that the client is receiving appropriate services as outlined in their individual habilitation plan and periodically reassessing the individual client's progress. i. ______ ______ ______

j. DISCHARGE. Terminating those services no longer needed or for which client is no longer eligible. j. ______ ______ ______

k. ADVOCACY. Representing and protecting the rights of the client. k. ______ ______ ______

l. COUNSELING. Talking with client about issues such as alternative service availability, risks and benefits before the individual service plan is written. l. ______ ______ ______

m. OTHER (Specify)________ m. ______ ______ ______
____

TOTAL: 100%

29. Using the following scale, indicate how effective you feel you are for each of the functions listed by circling the appropriate number.

			1 not effective	2 slightly effective	3 moderately effective	4 effective	5 very effective
a.	INTAKE. Determining a client's eligibility for services.	a.	1	2	3	4	5
b.	ASSESSMENT. Ascertaining a client's developmental level and specific needs for service.	b.	1	2	3	4	5
c.	PLANNING. Developing the individual service plan.	c.	1	2	3	4	5
d.	COORDINATION. Serving as a focal point for service. Coordinating among the diverse providers of service required by an individual.	d.	1	2	3	4	5
e.	DEVELOPING Individual Habilitation Plan. Developing a written plan of needs and goals for the individual client.	e.	1	2	3	4	5
f.	RECORDKEEPING. Maintaining comprehensive written records regarding intake information, strengths and needs assessment, goal and routine service planning, staff action, client progress and case review.	f.	1	2	3	4	5
g.	SUPPORT. Helping the individual and/or his/her family with unanticipated crisis intervention.	g.	1	2	3	4	5

h.	**LINKING AND BROKERING.** Referral for and development of new services as outlined in the Individual Habilitation Plan. This may include arranging for services at generic agencies, accompanying client to agencies, assist in completing forms or other activities which ensure that the client is linked to new services.	h.	1	2	3	4	5
i.	**MONITORING/FOLLOW-UP.** Assuring that the client is receiving appropriate services as outlined in their Individual Habilitation Plan and periodically reassessing the individual client's progress.	i.	1	2	3	4	5
j.	**DISCHARGE.** Terminating those services no longer needed or for which the client is no longer eligible.	j.	1	2	3	4	5
k.	**ADVOCACY.** Protecting and upholding the rights of the client.	k.	1	2	3	4	5
l.	**COUNSELING.** Talking with the client about issues such as alternative service availability, risks and benefits before the individual service plan is written.	l.	1	2	3	4	5
m.	Other (specify)____________	m.	1	2	3	4	5
n.	OVERALL EFFECTIVENESS.	n.	1	2	3	4	5

30. What gaps do you see in the case management system in your county/agency?

31. **What duplications do you see in the case management system in your county/agency?**

32. **Thinking of your role as case manager for clients with mental retardation or other related conditions, in which of the following topics do you feel you have a current need for more training? (Check those that apply.)**

a. Information on history, normalization, values a. ________

b. How to identify client's personal goals, preferences, strengths, and needs. b. ________

c. Methods for creative problem solving and for thinking innovatively. c. ________

d. Legal rights of clients and steps necessary to protect those rights. d. ________

e. How to assist clients in becoming their own case managers. e. ________

f. How to relate to and work with the various participating agencies. f. ________

g. How to coordinate/broker for services. g. ________

h. Methods to assist and refer clients in crises or emergency situations. h. ________

i. How to procure and analyze intake data to determine client eligibility for case management. i. ________

j. How to identify all pertinent information related to the client. j. ________

k. How to analyze initial client information and develop an individual service plan with the client. k. ________

l. How to develop an individual habilitation plan. l. ________

m. How to conduct interdisciplinary meetings. m. ________

n. How to participate effectively in the individual planning process. n. ________

o. Methods for procuring accurate information related to service options to meet individual client needs. o. ________

p. Methods for negotiating with clients and service providers when the client disagrees with individual plan components. p. ________

q. How to participate in periodic client reviews. q. ________

r. How to monitor quality of service to individual clients. r. ________

s. General information on developmental disabilities (mental retardation and other related conditions). s. ________

t. Other (Please specify) ________________ t. ________

Now, go back over the list and circle your check marks to indicate the three areas in which you believe it is most important that you receive training.

THANK YOU!

If we have questions about your responses, may we call you? If yes, may we have the following information? Your name, phone number. and responses will be kept confidential.

Name of person completing survey: ______________________________

Phone Number: ________________

CASE MANAGEMENT SURVEY

Consumers

		1	2
1.	Is a case manager currently assigned to you/your family?	Yes	No

2. If you have a case manager, please answer these questions:

a. What is your (consumer's) age? _____

b. Where do you (consumer) live? (check one)
1. at home with your family b1. _____
2. in a group home with more than 8 other people b2. _____
3. in a group home with 8 or fewer people b3. _____

3 Have you/your family member been diagnosed or classified as having:

		1	2
a.	mental retardation	Yes	No
b.	cerebral palsy	Yes	No
c.	epilepsy	Yes	No
d.	autism	Yes	No
e.	other (please specify) ____________________	Yes	No

4. This is a list of things your case manager should do for you. For each service you have received, please indicate how helpful/valuable you feel it is by circling a number, 1, 2, 3, 4 or 5. #1 means not helpful; #5 means very helpful. If you have not received a service, please check the last column.

		Not helpful 1	2	3	4	Very Helpful 5	Have not received
a.	ASSESSMENT. The case manager identified specific needs for services and wrote the individual service plan.	1	2	3	4	5	_____
b.	COORDINATION. The case manager organized and coordinated the services for me.	1	2	3	4	5	_____

c.	DEVELOP INDIVIDUAL HABILITATION PLAN. The case manager developed a written plan of my needs and goals.	1	2	3	4	5	____
d.	RECORDKEEPING. The case manager keeps records of information, plans, needs, progress and schedules.	1	2	3	4	5	____
e.	SUPPORT. The case manager helps me and/or my family with concerns, problems, and crises which occur.	1	2	3	4	5	____
f.	LINKING. The case manager arranges for services I need, goes with me to agencies, and helps me complete forms.	1	2	3	4	5	____
g.	MONITORING/FOLLOW-UP. The case manager makes sure that I receive the services I need. These services are written into a plan. The case manager evaluates my progress regularly and makes needed changes.	1	2	3	4	5	____
h.	DISCHARGE. The case manager ends services when I no longer need them.	1	2	3	4	5	____
i.	ADVOCACY. The case manager protects and upholds my rights and those of my family.	1	2	3	4	5	____
j.	COUNSELING. The case manager discusses my individual service plan with me before it is written. The case manager tells me about different services that are available to me, and the risks and benefits of each service.	1	2	3	4	5	____
k.	OTHER (Please list any other things your case manager has helped you with.)	______________					

5. Does your case manager prepare you for your staffings or for the staffings of your family member? (Please circle.) 1 Yes 2 No

6. How much time does your case manager spend with you or your family member each month (on the average)? ____________

7. How long have case management services been provided to you or your family member? Years ___ Months ___

8. During this time, how many case managers have you worked with? ____________

9. If you have worked with more than one case manager, please indicate how this change in case managers has affected you or your family member and the services you received.

   a. change in case managers has not affected services a. __________

   b. change in case managers caused a delay/disruption of services and planning b. __________

   c. change in case managers improved services c. __________

   d. other (please explain)____________________ d. __________
   ____

10. Have you or your family members received any training in working with the case management system? 1 Yes _____ 2 No _____

    If yes, where did you receive the training?

	1	2
- from formal college courses?	Yes _____	No _____
- from inservice/workshops?	Yes _____	No _____
- from an advocate?	Yes _____	No _____
- from the case manager?	Yes _____	No _____
- other (Please specify) ______________________		

11. Would you like to receive any training in working with the case management system? 1 Yes _____ 2 No _____

    If so, what type of training?
    (Please check the training possibilities you would like.)

    a. I would like to attend a workshop on how to work with the case management system. a. ________

b. I would like an advocate to teach me how to work with the case management system. b. ________

c. I would like a parent to teach me how to work with the case management system. c. ________

d. Other (please explain). d. ________

____

____

12. What gaps do you see in the case management system? Please list anything you think the case management system should provide that it does not provide now.

13. Have you ever had to wait for:

	1	2	If yes, how long?
a. an individual service plan to be developed?	a. Yes _____	b. No _____	_______
b. a service to be provided?	a. Yes _____	b. No _____	_______
c. a needed change in services?	a. Yes _____	b. No _____	_______

14. What things have been done for you by the case management system that you think were not necessary?

	1	2
15. Do you think that consumers/parents/guardians could act as their own case manager? (please circle)	Yes	No
	1	2
16. Do you act as case manager for yourself or your family member? (please circle)	Yes	No
	1	2
17. Do you act as an advocate for yourself or your family member? (please circle)	Yes	No
	1	2
18. Have you ever been asked to evaluate case management services? (please circle)	Yes	No
	1	2

19. Did you receive helpful case management services during these times?

	1	2	
- birth - 7 years	Yes ____	No ____	N/A ____
- 7-21 years	Yes ____	No ____	N/A ____
- 21-35 years	Yes ____	No ____	N/A ____
- 35-65 years	Yes ____	No ____	N/A ____
- 65 & older	Yes ____	No ____	N/A ____
- entering & exiting from school setting	Yes ____	No ____	N/A ____
- entering & exiting from residential settings	Yes ____	No ____	N/A ____

20. How would you rate the case management services you have received?

1	2	3	4	5
poor	fair	good	very good	excellent

21. What improvements or changes would you like to see in your case management services?

THANK YOU!

Your response on this questionnaire will be kept confidential. You are under no obligation to sign it.

If you do sign it, and we have questions about your responses, may we call you?
Yes ______ No ______.

Even if you do sign it, your name and phone number will not be given to anyone else.

Name of person completing survey: ________________

Phone Number: ________________

CASE MANAGEMENT SURVEY
ADVOCATES

Date: ____________

1. For which age levels of persons with developmental disabilities (mental retardation or other related conditions) do you act as an advocate?

Please check:

1.

a. birth through 5 years a. ____
b. 6 years through 21 years b. ____
c. 22 years and older c. ____

2. What is your highest educational degree?

2.

a. High School graduate a. ____
b. Bachelor's degree b. ____
c. Master's degree c. ____
d. Specialist degree d. ____
e. Ph.D./Ed.D. e. ____
f. Other (please specify) f. ____

3. Please check the areas in which you have had formal coursework and/or inservice training and indicate the year in which you received the training.

	formal coursework	year	inservice/ workshop	year
a. Case management	a1 ____	____	a2 ____	____
b. Developmental Disabilities	a1 ____	____	a2 ____	____
c. Services or Brokering/ negotiations	a1 ____	____	a2 ____	____
d. Individual Habilitation Plan/ Individual Service Plan/ Individual Educational Plan	a1 ____	____	a2 ____	____

4. How long have you been an advocate for persons with developmental disabilities?

_____ Years _____ Months

5. Below is a list of case management functions that county case managers perform. Based on your experience with mutual clients, how effective are county case managers in carrying them out?

1	2	3	4	5
Not Effective	Slightly Effective	Moderately Effective	Effective	Very Effective

a.	INTAKE. Determining a client's eligibility for services.	a.	1	2	3	4	5
b.	ASSESSMENT. Ascertaining a client's strengths and specific needs for service.	b.	1	2	3	4	5
c.	PLANNING. Developing the individual service plan.	c.	1	2	3	4	5
d.	COORDINATION. Serving as a focal point for service. Coordinating among the diverse providers of services required by an individual.	d.	1	2	3	4	5
e.	DEVELOP INDIVIDUAL HABILITATION PLAN. Developing a written plan of needs and goals for the individual client.	e.	1	2	3	4	5
f.	RECORDKEEPING. Maintaining comprehensive written records regarding intake information, strengths and needs assessment, goal and routine service planning, staff action, client progress and case review.	f.	1	2	3	4	5
g.	SUPPORT. Helping the individual and/or his/her family with unanticipated crisis intervention.	g.	1	2	3	4	5
h.	LINKING AND BROKERING. Referral for new services as outlined in the individual habilitation plan. This may include arranging for services at generic agencies, accompanying client to agencies, assisting in completing forms or other activities which ensure that the client is linked to new services.	h.	1	2	3	4	5

i.	**MONITORING/FOLLOW-UP.** Assuring that the client is receiving appropriate services as outlined in their individual habilitation plan and periodically reassessing the individual client's progress.	i.	1	2	3	4	5
j.	**DISCHARGE.** Terminating of those services no longer needed or eligible.	j.	1	2	3	4	5
k.	**ADVOCACY.** Protecting and upholding the rights of the client.	k.	1	2	3	4	5
l.	**COUNSELING.** Discussing issues such as alternative service availability, risks and benefits, etc.	l.	1	2	3	4	5
m.	**OTHER.** Please specify ______________________	m.	1	2	3	4	5

6. If, in working with a client with developmental disabilities, you perceive a need which is not currently being addressed, what steps/actions would you take? Please check:

a. notify case manager immediately a. _______
b. call for interdisciplinary team meeting b. _______
c. wait for interdisciplinary team meeting c. _______
d. notify client/guardian d. _______
e. other (specify) _____________ e. _______

7. What gaps currently exist in the provision of case management services to persons with developmental disabilities? Please list.

8. What duplications currently exist in the provision of case management services to persons with developmental disabilities? Please list.

9. In which of the following topics do you feel most case managers have a current need for more training?

_________ a. History, Normalization, Values

_________ b. How to identify client's personal goals, preferences, strengths, and needs.

_________ c. Methods for creative problem solving and for thinking innovatively.

_________ d. Legal rights of clients and steps necessary to protect those rights.

_________ e. How to assist clients in becoming their own service coordinators.

_________ f. How to relate to and work with the various participating agencies.

_________ g. Methods to assist and refer clients in crises or emergency situations.

_________ h. How to procure and analyze intake data to determine client eligibility for service coordination.

_________ i. How to identify all pertinent information related to the client.

_________ j. How to analyze initial client information and develop an individual service plan agreement with the client.

_________ k. How to function as a broker of service.

_________ l. Methods to facilitate the team consensus process.

_________ m. How to participate effectively in the individual planning process.

_________ n. Methods for procuring accurate information related to service options to meet individual client needs.

_________ o. Methods for negotiating with clients and service providers when the client disagrees with individual plan components.

_________ p. How to participate in periodic client reviews.

_________ q. How to monitor quality of service to individual clients.

_________ r. General information on developmental disabilities.

10. How could case management services for persons with developmental disabilities be improved? Please comment.

If we have questions about your responses, may we call you? If yes, may we have the following information? Your name, phone number, and responses will be kept confidential.

Name of person completing survey: __________________________

Phone Number: __________________

Thank you for your time and effort in completing and returning this survey.

CASE MANAGEMENT SURVEY
PUBLIC HEALTH NURSES

Date: ________________

1. a. What is your job title? a. ___________
   b. What is your employment setting? b. ___________

2. Please list areas in which you hold professional licensure/certification.

3. Are you a qualified mental retardation professional (QMRP) as stipulated in Medicaid ICF/MR regulations?

   1 Yes _____ 2 No _____

4. What is your educational background?

major(s)	degree(s)	
	a. baccalaureate	_____
	b. masters	_____
	c. doctorate	_____
	d. other	_____

5. Did you have any college courses which provided training in case management? If yes, please list under appropriate heading.

Before employment as Public Health Nurse case manager

Topic/title	Year attended

After employment as Public Health Nurse case manager

Topic/title	Year attended

6. What specific college courses have you had in the field of developmental disabilities (mental retardation or other related conditions)? Please list under appropriate heading.

Before employment as Public Health Nurse case manager

Topic/title	Year attended

After employment as Public Health Nurse case manager

Topic/title	Year attended

7. What inservice training experiences have you had that increased your knowledge/skills in case management and developmental disabilities?

Topic/title	Year attended

8. How long have you served as a case manager? ______ Years ______ Months
In what settings?

    a. Public Health ____
    b. County Agency ____
    c. Residential Program ____
    d. Day Program ____
    e. Other (please specify) ____

9. How long have you served as a case manager working with people with developmental disabilities? ______ Years ______ Months

10. How many persons with developmental disabilities whom you currently serve are in the following age groups and what are the disabilities?

Age Groups	Number	Disabilities
Birth through 5 yrs		
6 yrs through 21 yrs		
22 yrs through 30 yrs		
31 yrs through 60 yrs		
over 60 yrs		

11. If you were able to choose the makeup of your caseload, which would you choose?

    a. 100% clients with developmental disabilities a. ______
    b. Some, but not all, clients with developmental disabilities b. ______
    c. No clients with developmental disabilities c. ______

12. How many persons with developmental disabilities have you served on your caseload during 1986? ______

13. How many persons with developmental disabilities were removed from your caseload in 1986 because they have no longer needed health/case management services? ______

14. Of the persons with developmental disabilities currently on your caseload, how many have you served for:

    a. less than 1 year a. ______
    b. 1 - 5 years b. ______
    c. 5 - 10 years c. ______
    d. 10+ years d. ______

15. For how many other clients do you serve as case manager (not including clients with developmental disabilities)? ______

16. Please indicate the degree to which these factors act as barriers to your delivery of quality case management services. (Write appropriate #1-5 in space.)

1	2	3	4	5
Not a barrier	Seldom a barrier	Often a barrier (about 50% of the time)	Almost always a barrier	Always a barrier

a. Client level of disability a. ________

b. Service providers b. ________

c. Lack of training information on what you as a case manager should do c. ________

d. Lack of family involvement d. ________

e. Amount of time needed to interact with other agencies e. ________

f. Travel time/distance to client residence f. ________

g. Your current client caseload size g. ________

h. Paperwork h. ________

i. Too many meetings i. ________

j. Other: Please specify________________________ j. ________

17. When receiving new persons with developmental disabilities, do you do the following?

a. Orient them, their parents, or guardians to case management services?
1. Yes _____
2. No _____

b. Specifically explain the case management process to them?
1. Yes _____
2. No _____

c. Inform them that they have the opportunity to request another case manager if they are not satisfied with your services?
1. Yes _____
2. No _____

d. Contact your clients prior to their service plan review meeting to discuss this meeting with them?
1. Yes ___
2. No ___

18. How important do you feel it is for the client to participate in the service plan review meeting?

a. not important a. ___
b. somewhat important b. ___
c. very important c. ___

19. How often is consensus reached at the end of the service plan reviews you participate in?

a. never a. ___
b. sometimes b. ___
c. always c. ___

20. For each of the following statements, indicate if you feel it reflects a current responsibility of yours as a case manager serving persons with developmental disabilities. In the second column, indicate if you feel it should be your responsibility as a case manager:

		is my responsibility	should be my responsibility
A.	Ensure that the service plan review meeting is held	1 Yes ___ 2 No ___	1 Yes ___ 2 No ___
B.	Ensure that the resulting plan update is developed jointly by those invited	1 Yes ___ 2 No ___	1 Yes ___ 2 No ___
C.	Ensure that the client's views are heard and integrated into the plan	1 Yes ___ 2 No ___	1 Yes ___ 2 No ___
D.	Advocate for the client when he/she disagrees with the rest of the team	1 Yes ___ 2 No ___	1 Yes ___ 2 No ___
E.	Write the plan document and distribute it to client and team members	1 Yes ___ 2 No ___	1 Yes ___ 2 No ___

21. Do your clients/parents/guardians know that, if they are able, they may take an active role in procuring, adapting and arranging the services identified in the service plan?

usually a. _____
sometimes b. _____
seldom c. _____

22. How do you monitor the progress of the service plan?

a. visit the client at the service sites while services are being provided? a. 1 Yes ___ 2 No ___

b. review service providers' records and reports b. 1 Yes ___ 2 No ___

c.	hold periodic client interviews	c.	1 Yes ___	2 No ___
d.	hold periodic family interviews	d.	1 Yes ___	2 No ___
e.	hold annual review meeting	e.	1 Yes ___	2 No ___
f.	revise individual service and habilitation plans as needed	f.	1 Yes ___	2 No ___
g.	other (please specify) ________________	g.	1 Yes ___	2 No ___

23. When you have identified a service need for your client with disabilities, but the needed service is unavailable, do you:

a.	write the need into the individual service plan	a.	1 Yes ___	2 No ___
b.	postpone writing the need into the individual service plan until services are available	b.	1 Yes ___	2 No ___
c.	recommend appropriate alternatives	c.	1 Yes ___	2 No ___
d.	set date to review alternative service needs	d.	1 Yes ___	2 No ___
e.	find/assign someone to develop needed services	e.	1 Yes ___	2 No ___
f.	notify the proper authorities of the gap in services	f.	1 Yes ___	2 No ___
g.	wait until the annual review meeting	g.	1 Yes ___	2 No ___
h.	schedule a review meeting	h.	1 Yes ___	2 No ___

24. Please indicate below the case management functions you typically perform and estimated monthly percentage of time (based on 1 FTE) you spend on each function.

			1 YES	2 NO	EST %TIME
a.	INTAKE. Determining a client's eligibility for services.	a.	______	______	______
b.	ASSESSMENT. Ascertaining a client's strengths and specific needs for service.	b.	______	______	______
c.	PLANNING. Developing the individual service plan.	c.	______	______	______
d.	COORDINATION. Serving as a focal point for service. Coordinating among the diverse providers of service required by an individual.	d.	______	______	______
e.	DEVELOP INDIVIDUAL HABILITATION PLAN. Developing a written plan of needs and goals for the individual client.	e.	______	______	______
f.	RECORDKEEPING. Maintaining comprehensive written records regarding intake information, strengths and needs assessment, goal and routine service planning, staff action, client progress and case review.	f.	______	______	______
g.	SUPPORT. Helping the individual and/or his/her family with unanticipated crisis intervention.	g.	______	______	______
h.	LINKING AND BROKERING. Referral for new services as outlined in the individual habilitation plan. This may include arranging for services at generic agencies, accompanying client to agencies, assisting in completing forms or other activities which ensure that the client is linked to new services.	h.	______	______	______

i. **MONITORING/FOLLOW-UP.** Assuring that the client is receiving appropriate services as outlined in their individual habilitation plan and periodically reassessing the individual client's progress. i. ______ ______ ______

j. **DISCHARGE.** Terminating those services no longer needed or for which the client is no longer eligible. j. ______ ______ ______

k. **ADVOCACY.** Representing and protecting the rights of the client. k. ______ ______ ______

l. **COUNSELING.** Discussing issues such as alternative service availability, risks and benefits, etc. l. ______ ______ ______

m. **OTHER (Specify)** m. ______

25. Using the following scale, indicate how effective you believe you are for each of the functions listed. Please circle.

1	2	3	4	5
not effective	slightly effective	moderately effective	effective	very effective

a. **INTAKE.** Determining a client's eligibility for services. a. 1 2 3 4 5

b. **ASSESSMENT.** Ascertaining a client's strengths and specific needs for service. b. 1 2 3 4 5

c. **PLANNING.** Developing the individual service plan. c. 1 2 3 4 5

d. **COORDINATION.** Serving as a focal point for service. Coordinating among the diverse providers of service required by an individual. d. 1 2 3 4 5

e.	DEVELOP INDIVIDUAL HABILITATION PLAN. Developing a written plan of needs and goals for the individual client.	e.	1	2	3	4	5
f.	RECORDKEEPING. Maintaining comprehensive written records regarding intake information, strengths and needs assessment, goal and routine service planning, staff action, client progress and case review.	f.	1	2	3	4	5
g.	SUPPORT. Helping the individual and/or his/her family with unanticipated crisis intervention.	g.	1	2	3	4	5
h.	LINKING AND BROKERING. Referral for new services as outlined in the individual Habilitation Plan. This may include arranging for services at generic agencies, accompanying client to agencies, assisting in completing forms or other activities which ensure that the client is linked to new services.	h.	1	2	3	4	5
i.	MONITORING/FOLLOW-UP. Assuring that the client is receiving appropriate services as outlined in their individual habilitation plan and periodically reassessing of the individual client's progress.	i.	1	2	3	4	5
j.	DISCHARGE. Termination of those services no longer needed or for which the client is no longer eligible.	j.	1	2	3	4	5
k.	ADVOCACY. Protecting and upholding the rights of the client.	k.	1	2	3	4	5
l.	COUNSELING. Discussing issues such as alternative service availability, risks and benefits, etc.	l.	1	2	3	4	5

m.	OTHER (specify)	m.	1	2	3	4	5
n.	OVERALL EFFECTIVENESS	n.	1	2	3	4	5

		1	2
27.	Do you have job responsibilities not related to case management?	Yes___	No ___

28. If Yes to Question 27, indicate what other responsibilities you have:

		1	2
a.	Supervision of other public health nurses	a. Yes ___	No ___
b.	Administrative in-service training (not client specific)	b. Yes ___	No ___
c.	Administrative paperwork (other than client record-keeping	c. Yes ___	No ___
d.	Public education	d. Yes ___	No ___
e.	Outreach	e. Yes ___	No ___
f.	Resource Identification	f. Yes ___	No ___
g.	Other (specify)	g. Yes ___	No ___

29. What gaps do you see in the case management services in your agency/facility?

30. What duplications do you see in the case management services in your agency/facility?

31. Thinking of your role as case manager for clients with developmental disabilities, in which of the following topics do you feel you have a current need for more training?

a. History, normalization, values. a. ______

b. How to identify client's personal goals, preferences, strengths, and needs. b. ______

c. Methods for creative problem solving and for thinking innovatively. c. ______

d. Legal rights of clients and steps necessary to protect those rights. d. _______

e. How to assist clients in becoming their own case managers. e. _______

f. How to relate to and work with the various participating agencies. f. _______

g. Methods to assist and refer clients in crises or emergency situations. g. _______

h. How to procure and analyze intake data to determine client eligibility for case managers. h. _______

i. How to identify all pertinent information related to the client. i. _______

j. How to analyze initial client information and develop an individual service plan with the client. j. _______

k. How to function as a broker of service. k. _______

l. Methods to facilitate the team consensus process. l. _______

m. How to participate effectively in the individual planning process. m. _______

n. Methods for procuring accurate information related to service options to meet individual client needs. n. _______

o. Methods for negotiating with clients and service providers when the client disagrees with individual plan components. o. _______

p. How to participate in periodic client reviews. p. _______

q. How to monitor quality of service to individual clients. q. _______

r. General information on developmental disabilities. r. _______

s. Other - please specify s. _______

Now, go back over the list and circle your check marks to indicate the three areas in which you believe it is most important that you receive training.

THANK YOU!

If we have questions about your responses, may we call you? If yes, may we have the following information? Your name, phone number, and responses will be kept confidential.

Name of person completing survey: ________________

Phone Number: ________________

CASE MANAGEMENT SURVEY
SERVICE PROVIDERS

Date: ______________

1. What type of services do you provide for people with developmental disabilities (mental retardation or other related conditions)?

a. residential	a. ______
b. day program	b. ______
c. support	c. ______
d. other	d. ______

2. How many clients with developmental disabilities did you provide services for during January 1 through December 31, 1986? ________

3. What is the total number of clients (with developmental disabilities, mental illness, etc.) for whom you provided services during January 1 through December 31, 1986? ________

4. For each of the four areas listed below, please check the area which best describes the training you have had in that area. You may check more than one of the options a, b, or c, if appropriate.

	Year of Training
Case Management	
______ a) formal college course work	________
______ b) inservice/workshop	________
______ c) other (please specify)	________
______ d) no training	________
Developmental disabilities	
______ a) formal college course work	________
______ b) inservice/workshop	________
______ c) other (please specify)	________
______ d) no training	________
Brokering/negotiating services	
______ a) formal college course work	________
______ b) inservice/workshop	________
______ c) other (please specify)	________
______ d) no training	________

Development of Individual Plans/Programs

_______ a) formal college course work a. __________
_______ b) inservice/workshop b. __________
_______ c) other (please specify) c. __________
_______ d) no training d. __________

5. a. What is the average time lapse between the writing of the Individual Service Plan and the initiation of services? a. _________

b. What is the average time lapse between the writing of the Individual Habilitation Plan and the initiation of services? b. _________

6. a. Are you involved in the writing of the Individual Habilitation Plan?

a. Yes 1 _____ No 2 _____

b. If not, would you like to be? b. Yes 1 _____ No 2 _____

7. a. How many case managers did you deal with during January 1 through December 31, 1986? a. _________

b. How many different counties did you deal with in 1986? b. ______

8. If, in working with a person with developmental disabilities, you perceive a need which is not currently being addressed, what steps would you take? (Please check all that apply.)

a. notify case manager immediately a. __________
b. call for interdisciplinary team meeting b. __________
c. wait for interdisciplinary team meeting c. __________
d. notify client/guardian d. __________
e. other (please specify) e. __________

9. On the average, how much time do you spend monthly on paperwork for each client with developmental disabilities?

____

10. On the average, how much time do you spend monthly in meetings regarding each client with developmental disabilities?

____

11. a. Is evaluation of case management services ever performed? Yes 1 ___ No 2 ___

b. Have you ever participated in this evaluation? Yes 1 ___ No 2 ___

12. If yes, how often do you evaluate case management services: (Please check)

a. yearly a. ____________
b. twice a year b. ____________
c. four times a year c. ____________
d. monthly d. ____________
e. other e. ____________

13. Below is a list of case management functions that "Rule 185 county case managers" perform. Based on your experience with mutual clients, how effective do you believe county case managers are in carrying them out?

0	1	2	3	4	5
Unknown	Not Effective	Slightly Effective	Moderately Effective	Effective	Very Effective

a.	INTAKE. Determining a client's eligibility for services.	0	1	2	3	4	5
b.	ASSESSMENT. Ascertaining a client's strengths and specific needs for service.	0	1	2	3	4	5
c.	PLANNING. Developing the individual service plan.	0	1	2	3	4	5
d.	COORDINATION. Serving as a focal point for service. Coordinating among the diverse providers of services required by an individual.	0	1	2	3	4	5
e.	DEVELOPING INDIVIDUAL HABILITATION PLAN. Developing a written plan of needs and goals for the individual client.	0	1	2	3	4	5
f.	RECORDKEEPING. Maintaining comprehensive written records regarding intake information, strengths and needs assessment, goal and routine service planning, staff action, client progress and case review.	0	1	2	3	4	5
g.	SUPPORT. Helping the individual and/or his/her family with unanticipated crisis intervention.	0	1	2	3	4	5
h.	LINKING AND BROKERING. Referral or development of services as outlined in the client's plan of services. This may include arranging for services at generic agencies, accompanying client to agencies, assisting in completing forms or other activities which ensure that the client is linked to new services.	0	1	2	3	4	5

i.	**MONITORING/FOLLOW-UP.** Assuring that the client is receiving appropriate services as outlined in their service plan and periodically reassessing the individual client's progress.	0	1	2	3	4	5
j.	**CASE CLOSURE. DISCHARGE.** Terminating those services no longer needed or for which client is no longer eligible.	0	1	2	3	4	5
k.	**OVERALL EFFECTIVENESS.**	0	1	2	3	4	5

14. In your opinion, what other functions could case management provide which would support the provision of services? Please specify.

15. Do case managers provide you with sufficient information to arrange for appropriate services?

a. Usually	a. ______
b. Seldom	b. ______
c. Never	c. ______

If not, please specify what other information would be helpful.

If we have questions about your responses, may we call you? If yes, may we have the following information? Your name, phone number, and responses will be kept confidential.

Name of person completing survey: ______________________

Phone Number: ________________

Thank you for your time and effort in completing and returning this survey.

CASE MANAGEMENT SURVEY
SCHOOL PERSONNEL

(For case managers of students who are autistic, multiply-handicapped, and trainable mentally retarded.)

Date: ________________

1. What is your educational background?

Major	Degrees
	a. Baccalaureate _____ b. Master's _____ c. Doctorate _____ d. Other (please specify) _____

2. Please check the item(s) which describes your current position and fill in how long you have been in that position.

		how long
a. Teacher	a. _____	_____
b. School Social Worker	b. _____	_____
c. School Nurse	c. _____	_____
d. School Psychologist	d. _____	_____
e. Educational Case Manager/ Services Coordinator	e. _____	_____
f. Due Process Coordinator/ Specialist	f. _____	_____
g. Other (please specify) ____________________	g. _____	_____

3. How long have you acted as a special education case manager? _____ years _____ months

In what settings? (check all that apply)

a. Level 2 consultation a. _____

b. Resource classroom b. _____

c. Self-contained classroom c. _____

d. Residential setting d. _____

e. Regular education setting e. _____

f. other (please specify) f. _____

4. What training (workshop and courses) have you had that prepared you for the role of special education case manager?

Title/Topic	Year Attended

5. What training (workshops and courses) have you had that prepared you to work with students who are severely handicapped?

Title/Topic	Year Attended

6. What training (workshops and courses) have you had on transition planning (movement from special education to adult services)?

Title/Topic	Year Attended

7. Please check areas in which you hold current professional licensure/certification.

a. Regular Education Teacher (elementary) a. _____

b. Regular Education Teacher (secondary) b. _____

c. Trainable Mentally Handicapped c. _____

d. Educably Mentally Handicapped d. _____

e. Hearing Impaired e. _____

f. Visually Impaired f. _____

g. Physically Handicapped g. _____

h. Learning Disabled h. _____

i. Emotionally/Behaviorally Disordered i. _____

j. Speech Therapy j. _____

k. School Administrator k. _____

l. Supervisory l. _____

m. Other _______________ m. _____

8. How are case management services typically handled in your school? (Please check one)

   a) A staff person who is also providing direct services to the student is assigned the case manager role. a. _____

   b) A staff person who is not providing direct service to the student is assigned the case manager role. b, _____

   c) Educational case management or Due Process specialists provide case management services. c. _____

   d) Other - Please explain. d. _____

9. As a special education case manager, do you assist with the management of:

   1 2

   a) School-based services only a. Yes _____ No _____

   b) Planning for post-secondary services b. Yes _____ No _____

   c) Other (please specify) c. Yes _____ No _____

10. As a special education case manager, it is my responsibility to:

   1 2

   A. Ensure that the individual education plan review meeting is held a. Yes _____ No _____

   B. Ensure that the resulting plan update is developed jointly by those invited b. Yes _____ No _____

   C. Ensure that the student's/family's views are heard and integrated into the plan c. Yes _____ No _____

   D. Advocate for the student/family when he/she disagrees with the rest of the team d. Yes _____ No _____

   E. Write the individual education plan and distribute it to student/family and team members e. Yes _____ No _____

11. From January 1986 - December 1986, approximately what percentage of Individual Education Plan (IEP) meetings (on students for whom you are case manager) were attended by a parent or guardian? _________

		1	2
12.	Do you monitor the degree to which the IEP objectives are met?	Yes ___	No ___

If yes, how do you monitor?

	1	2
a. Periodic visits to student during the school day	a. Yes _____	No _____
b. Review teacher's records and reports	b. Yes _____	No _____
c. Hold periodic student interviews	c. Yes _____	No _____
d. Hold periodic family interviews	d. Yes _____	No _____
e. Hold annual review meeting	e. Yes _____	No _____
f. Revise individual education plan as needed	f. Yes _____	No _____

g. Other (please specify) ____________________

13. When you have identified a need for a student with disabilities, but the needed service is unavailable, do you:

	1	2
a. write the need into the IEP?	a. Yes _____	No _____
b. postpone writing the need into the IEP until services are available?	b. Yes _____	No _____
c. recommend appropriate alternatives?	c. Yes _____	No _____
d. set date to review alternative program/service needs ?	d. Yes _____	No _____
e. find/assign someone to develop needed program/services?	e. Yes _____	No _____
f. notify the proper authorities of the gap in program/services?	f. Yes _____	No _____
g. wait until the annual review meeting?	g. Yes _____	No _____
h. schedule a review meeting?	h. Yes _____	No _____

14. What percent of your students in each age range receive services from vocational education through a formal vocational education program? (It may be a school-based vocational education program.)

a. 6 years through 15 years a. _____

b. 16 years through 21 years b. _____

15. Please indicate below the case management functions you typically perform and estimated monthly percentage of time you spend on each function (figure on the basis of your total job). Also, using the following scale, indicate how effective you believe you are for each of the functions listed.

1	2	3	4	5
not effective	slightly effective	moderately effective	effective	very effective

- - - - - - - - - -

	1 YES	2 NO	EST %TIME in typical month	Rating of effectiveness (1-5)
a. SCREENING. Determining a student's eligibility for services.	_____	_____	_____	_____
b. ASSESSMENT. Ascertaining a student's strengths and specific needs for service.	_____	_____	_____	_____
c. COORDINATION. Serving as a focal point for service. Coordinating among the diverse services required by an individual.	_____	_____	_____	_____
d. DEVELOP INDIVIDUAL EDUCATION PLAN. Developing a written plan of needs and goals for the individual student.	_____	_____	_____	_____
e. RECORDKEEPING. Maintaining comprehensive written records regarding intake information, strengths and needs assessment, goal and routine service planning, staff action, student progress and case review.	_____	_____	_____	_____

f.	**SUPPORT.** Helping individuals and/or their families with unanticipated crisis intervention and locating community/school resources.	_____	_____	_____	_____
g.	**INTER-AGENCY ACTIVITIES.** Referral for new services as outlined in the Individual Education Plan. This may include arranging for services at generic agencies, accompanying student/parent/guardian to agencies, assist in completing forms or other activities which ensure that the student is linked to new services.	_____	_____	_____	_____
h.	**MONITORING/FOLLOW-UP.** Assuring that the student is receiving appropriate services as outlined in their Individual Education Plan and periodically reassessing the individual student's progress.	_____	_____	_____	_____
i.	**DISCHARGE.** Terminating those services no longer needed or for which the student is no longer eligible.	_____	_____	_____	_____
j.	**ADVOCACY.** Representing and protecting the rights of the student.	_____	_____	_____	_____
k.	**COUNSELING.** Discussing issues such as alternative service availability, risks and benefits, etc.	_____	_____	_____	_____
l.	**OTHER.** School/case management duties (specify)	_____	_____	_____	_____

16. What problems or concerns have you experienced with your case management responsibilities?

17. Thinking of your role as case manager for students, in which of the following topics do you feel you have a current need for more training?

a. History, normalization, values a. ______

b. How to identify student's personal goals, preferences, strengths, and needs. b. ______

c. How to plan and implement effective programs. c. ______

d. Methods for creative problem solving in the team process and for thinking innovatively. d. ______

e. Legal rights of students/families and steps necessary to protect those rights. e. ______

f. How to assist students/families in self-advocacy activities. f. ______

g. How to relate to and work with the various participating disciplines and related services. g. ______

h. Methods to assist and refer students/families in crises or emergency situations. h. ______

i. How to analyze initial student information and develop an individual education plan with the student/parents. i. ______

j. Methods to facilitate the team consensus process. j. ______

k. How to involve other essential agencies, parents, and students. k. ______

l. How to participate in periodic IEP reviews. l. ______

m. How to monitor individual program plans. m. ______

n. More information on: n. ______
    curriculum ______
    assessment ______
    community-based instruction ______
    transition ______

o. Other - please specify o. ______

Now, go back over the list and circle your check marks to indicate the three areas in which you believe it is most important that you receive training.

THANK YOU!

If we have questions about your responses, may we call you? If yes, may we have the following information? (Your name and phone number will be kept confidential).

Name of person completing survey: ____________________________

Phone Number: _________________

CASE MANAGEMENT SURVEY
DIVISION OF REHABILITATION SERVICES COUNSELORS

Date: ________________

Job Preparation and Tenure

1. What is your academic background? Circle one in each column.

Major	Degree(s)
	a. Baccalaureate _____
	b. Masters _____
	c. Doctorate _____
	d. Other _____

2. Have you had any training in the following areas in the past year?

			1	2
a.	Rule 185 County Case Management Services	a.	Yes _____	No _____
b.	Developmental Disabilities (mental retardation or other related conditions)	b.	Yes _____	No _____
c.	Brokering/negotiations	c.	Yes _____	No _____
d.	Individualized Habilitation Planning (IHP)	d.	Yes _____	No _____
e.	Individualized Service Planning (ISP)	e.	Yes _____	No _____
f.	Inter-agency Coordination of Services	f.	Yes _____	No _____

3. How long have you been a counselor in the Division of Rehabilitation Services?

________ Years ________ Months

4. What other job related or volunteer experiences have you had with people with developmental disabilities (mental retardation or other related conditions)?

Caseload Information

5. What is your approximate caseload size per year? ________

6. What is the approximate number of persons with developmental disabilities (mental retardation or other related conditions) you serve per year? ________

7. What percentage of your case load time is spent with people with developmental disabilities? ________

8. Do you know what "Department of Human Services, Rule 185 Case Management Services" are?

1	2
Yes _____	No _____

9. On how many cases did you work cooperatively with a "Rule 185 County Case Manager" during January 1 through December 31, 1986? __________

If you answered No to Question 8 or None to Question 9, please go directly to Question 14 and do not answer Questions 10 - 13.

10. How many different Rule 185 case managers did you deal with during the past year? ________

11. How do the case coordination services you provide differ from "Rule 185 case management services" provided by county human services personnel?

12. Below is a list of case management functions that "Rule 185 county case managers" perform. Based on your experience with mutual clients, how effective do your believe county case managers are in carrying them out?

0	1	2	3	4	5
Unknown	Not Effective	Slightly Effective	Moderately Effective	Effective	Very Effective

a.	INTAKE. Determining a client's eligibility for services.	0	1	2	3	4	5
b.	ASSESSMENT. Ascertaining a client's strengths and specific needs for service.	0	1	2	3	4	5
c.	PLANNING. Developing the individual service plan.	0	1	2	3	4	5
d.	COORDINATION. Serving as a focal point for service. Coordinating among the diverse providers of services required by an individual.	0	1	2	3	4	5
e.	DEVELOPING INDIVIDUAL HABILITATION PLAN. Developing a written plan of needs and goals for the individual client.	0	1	2	3	4	5

f.	**RECORDKEEPING.** Maintaining comprehensive written records regarding intake information, strengths and needs assessment, goal and routine service planning, staff action, client progress and case recorder.	0	1	2	3	4	5
g.	**SUPPORT.** Helping the individual and/or his/her family with unanticipated crisis intervention.	0	1	2	3	4	5
h.	**LINKING AND BROKERING.** Referral for development of services as outlined in the client's plan of services. This may include arranging for services at generic agencies, accompanying client to agencies, assisting in completing forms or other activities which ensure that the client is linked to new services.	0	1	2	3	4	5
i.	**MONITORING/FOLLOW-UP.** Assuring that the client is receiving appropriate services as outlined in their service plan and periodically reassessing of the individual client's progress.	0	1	2	3	4	5
j.	**CASE CLOSURE. DISCHARGE.** Terminating those services no longer needed or for which client is no longer eligible.	0	1	2	3	4	5
k.	**OVERALL EFFECTIVENESS.**	0	1	2	3	4	5

13. To what degree do you think the following factors impede the effectiveness of current county case management services with mutual clients?

0	1	2	3	4	5
Unknown	Never a barrier	Seldom a barrier	Often a barrier (about 50% of the time)	Almost always a barrier	Always a barrier

A. GENERAL CONSIDERATIONS

a.	Client level of disability	0	1	2	3	4	5
b.	Service providers	0	1	2	3	4	5
c.	Lack of training/information on what you as a case manager should do	0	1	2	3	4	5
d.	Lack of family involvement	0	1	2	3	4	5

	e.	Amound of time needed to interact with other agencies	0	1	2	3	4	5
	f.	Travel time/distance to client residence	0	1	2	3	4	5
	g.	Your current client caseload size	0	1	2	3	4	5
	h.	Paperwork	0	1	2	3	4	5
	i.	Too many meetings	0	1	2	3	4	5
B.	STAFFING							
	1.	Staff shortages	0	1	2	3	4	5
	2.	Staff turnover	0	1	2	3	4	5
	3.	Reduction in force (layoffs) of case management staff	0	1	2	3	4	5
C.	AVAILABILITY OF PROGRAMS							
	1.	Lack of residential program options	0	1	2	3	4	5
	2.	Lack of day program options	0	1	2	3	4	5
	3.	Difficult access for the client to generic agency program/services by or for the client	0	1	2	3	4	5
D.	FUNDING							
	1.	Insufficient funds	0	1	2	3	4	5
	2.	Delays in receiving funds	0	1	2	3	4	5
	3.	Restrictions in use of funds	0	1	2	3	4	5
E.	COUNTY ADMINISTRATION							
	1.	Lack of routine planning and coordination within own agency	0	1	2	3	4	5
	2.	Coordination between program units	0	1	2	3	4	5
	3.	Internal reorganization	0	1	2	3	4	5

F. INTER-AGENCY ADMINISTRATION

1.	Lack of routine planning and coordination among service providers at the local level for a client	0	1	2	3	4	5
2.	Difficulty in communication among agencies at the local level	0	1	2	3	4	5
3.	Confidentiality issues that inhibit flow of necessary information on clients	0	1	2	3	4	5
4.	Lack of information or understanding about other agencies, programs, resources, & problems	0	1	2	3	4	5
5.	Inappropriate referrals	0	1	2	3	4	5
6.	Duplication of services	0	1	2	3	4	5
7.	Multiple individual plans for a single client	0	1	2	3	4	5
8.	Clients "falling into the cracks" between agencies	0	1	2	3	4	5
9.	Lack of clear understanding of which agency is responsible for client's case management	0	1	2	3	4	5
10.	Multiple case managers/client coordinators for a single client	0	1	2	3	4	5

14. What additional functions could "Rule 185 County Case Managers" provide which would support the provision of services your agency delivers?

15. Are you involved in the development of the individual service plan?
1 Yes _____ 2 No _____

a. If yes,
    1. for how many clients? _______
    2. during what period of time? from _____ to _____

b. If no, would you like to be involved?
1 Yes _____ 2 No _____

16. Are you involved in the individual habilitation plan?
1 Yes _____ 2 No _____

a. If yes,
    1. for how many clients? _______
    2. during what period of time? from _____ to _____

b. If no, would you like to be involved?
1 Yes _____ 2 No _____

17. When orienting new clients, do you inform them about Department of Human Services case management?
1 Yes _____ 2 No _____

18. Do you contact your clients/parents/guardian prior to initiating their Individual Written Rehabilitation Plan (IWRP) process to discuss this with them?

a. Always a. _____
b. Sometimes b. _____
c. Never c. _____

19. How important do you feel it is for the client to participate in the IWRP process?

a. Very Important a. _____
b. Important b. _____
c. Not Important c. _____

20. How often is consensus reached at the end of the IWRP process with the client?

a. Always a. _____
b. Sometimes b. _____
c. Never c. _____

21. What approach do you take when consensus is not reached?

22. Do you encourage the clients/parents/guardians who are able to do so to take an active role in procuring, adapting and arranging the services identified in the Individual Written Rehabilitation Plan?

a. Always a. ______
b. Sometimes b. ______
c. Never c. ______

23. How do you monitor provision of services outlined in the IWRP. Please check ( ).

a. Periodic client interviews. a. ______

b. Individual evaluation criteria and methods specified on the IWRP are identified and carried out. b. ______

c. Contact with county case manager. c. ______

d. Service provider contact. d. ______

e. Family/client contact. e. ______

f. Annual IWRP review. f. ______

g. Other (Please specify). g. ______

24a. What gaps do you see in your agency's client service coordinating system?

Please list any suggestions for improvement.

24b. What duplications do you see in your agency's client service coordinating system?

Please list any suggestions for improvement.

25a. What gaps do you see within the county case management system?

Please list any suggestions for improvement.

25b. What duplications to you see within the county case management system?

Please list any suggestions for improvement.

26. Thinking of your role as a vocational rehabilitation counselor serving persons with developmental disabilities, in which of the following topics have you had training or do you feel you need training in? Check all of the topics which apply.

		Have had training	Need training
a.	Information on history, values, normalization.	a1_____	a2_____
b.	How to identify client's personal goals, preferences, strengths, and needs.	b1_____	b2_____
c.	Methods for creative problem solving and for thinking innovatively.	c1_____	c2_____
d.	Legal rights of clients and steps necessary to protect those rights.	d1_____	d2_____

e.	How to assist clients in becoming their own service coordinators.	e1____	e2____
f.	How to relate to and work with the various participating agencies.	f1____	f2____
g.	Methods to assist and refer clients in crises or emergency situations.	g1____	g2____
h.	How to procure and analyze intake data to determine client eligibility for DRS.	h1____	h2____
i.	How to identify all pertinent information rated to the client.	i1____	i2____
j.	How to analyze initial client information and develop a formal agreement with the client.	j1____	j2____
k.	How to function as a broker of service.	k1____	k2____
l.	Methods to facilitate the team consensus process.	l1____	l2____
m.	How to participate effectively in the individual work rehabilitation planning process.	m1____	m2____
n.	Methods for procuring accurate information related to service options to meet individual client needs.	n1____	n2____
o.	Methods for negotiating with clients and service providers when the client disagrees with individual plan components.	o1____	o2____
p.	How to participate in periodic client reviews.	p1____	p2____
q.	How to monitor quality of service to individual clients.	q1____	q2____
r.	General information on developmental disabilities.	r1____	r2____

Now, go back over the list and select from the items you have checked the three areas you believe it is most important that you receive training in. Circle the three checks by the topics you feel are the most needed training areas.

Thank you.

If we have questions about your responses, may we call you? If yes, may we have the following information? Your name, phone number, and responses will be kept confidential.

Name of person completing survey: ________________________

Phone number: ______________________________